Appendix I

Southeast Trauma Care Region Trauma Plan

I. Trauma Plan Summary

The Trauma Plan of the Southeast Trauma Care Region, Inc. (SETCR) has been prepared in accordance with all of the requirements set forth in published rules of the Mississippi State Department of Health dated April 6, 2000 and entitled “The Mississippi Trauma Care System Regulations.”

The purpose of this plan is to progressively develop an inclusive trauma care system for the state designated 13-county SETCR.

The SETCR is a public not for profit 501-C3 chartered organization which is governed by an 18-member Board of Directors. Members of the SETCR Board represent the participating counties: Covington, Forrest, Greene, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, Stone, Walthall, and Wayne.

Management of the SETCR has been established through a contract with AAA Ambulance Service (AAA) in Hattiesburg, Mississippi. The Chief Executive Officer of AAA serves as CEO of the SETCR and is responsible, under the direction of the SETCR Board of Directors, for the region’s inclusive trauma system – planning, implementation, and management.

This plan blueprints the initial development of an inclusive trauma care system within an existing emergency medical system in Southeast Mississippi. The plan’s foundation exists within the area’s participating hospitals (one Level II facility, one Level III facility,

and eight Level IV facilities), medical staffs, pre-hospital providers, ancillary support groups, consumers, and political subdivisions.

Additional tertiary care is available formally through an agreement with the state's only Level I facility, University Medical Center located in Jackson. Out-of-state facilities located in New Orleans, Louisiana and Mobile, Alabama will be contacted to develop similar agreements during FY 2005.

Major trauma patients within twenty minutes of the Level II facility will be transported directly to that facility. The location of more distant patients may often require patients to be evaluated at a closer Level III or Level IV facility and, if appropriate, transferred to the Level II trauma center.

Because of the availability of advanced life support pre-hospital providers and a rapid air transport system from the Southeast Mississippi Air Ambulance District, some of the more distant major trauma patients may be transported directly to the region's Level II trauma center by order of online regional medical directors and/or protocols as authorized in the regional medical control plan.

Other special care needs of trauma patients are available by formal agreements with Delta Medical Center (burn center) in Greenville and Methodist Rehabilitation Center (rehabilitation) in Jackson. Additionally, burn center care is available at the University of South Alabama in Mobile.

II. Plan Objectives

A. SETCR Goals

1. To develop and implement an inclusive regional trauma care system which is founded upon an existing pre-hospital system (EMS) and upon in-region hospital facilities with support and commitment from the respective medical staffs.
2. To establish an administrative structure that will be able to plan and implement an inclusive trauma system with the anticipation that preventable morbidity and mortality resulting from trauma will be reduced.
3. To develop and implement a regional trauma registry which will serve as the basis for which all trauma system processes can be based.
4. To develop and implement public information, education, and prevention programs with the goals of accessibility to care, system support, and lifestyle changes (incidence reduction).

B. SETCR Detailed Objectives

1. <u>Finalize contract between SETCR and AAA Ambulance Service.</u>

   A contract between the SETCR and AAA Ambulance Service will be negotiated on an annual basis with the program year to be July 1 through June 30 of each year. This contract will enable AAA Ambulance Service to serve as the lead agency for trauma systems development for the member counties forming the SETCR. The

success of this management agreement will be measured annually by the SETCR Board of Directors.

2. Facilitate and direct the financial support of the SETCR from local, state and federal services, if any.

   Financial support of the SETCR is managed by AAA Ambulance Service. This is accomplished through support services rendered by AAA personnel and a financial contract with the Horne CPA Group. AAA is responsible for funds received from the State of Mississippi through the statutorily created Trauma Care Trust Fund. Program activities and data gathered through the local and regional trauma registry databases serve as a conduit for receipt of these funds. Hospital and physician reimbursement and the production of program activities conducted by the SETCR serve as evaluation tools annually.

3. Assist hospitals with the trauma center designation process.

   Staff of the SETCR (physician, nursing, trauma registry, administration) assists all participant hospitals and guide the development of local trauma programs within these facilities. These activities will assist these hospital facilities in obtaining and maintaining their trauma center designation.

4. Facilitate all meetings of the SETCR Board of Directors and other committees established by the Board, i.e., regional advisory committees, clinical, administrative, and system committees.

Meetings of the SETCR Board of Directors and all established committees are facilitated by the regional staff. These meetings are conducted quarterly at a minimum.

5. Hire part-time personnel: Trauma Nurse and Regional Secretary.

   Part-time personnel in addition to the CEO are employed as follows: Regional Trauma Nurse Coordinator, Regional Secretary (Administrative Assistant), Regional Trauma Registrar, and Regional Trauma Medical Director. These personnel will carry out the program activities approved by the Board of Directors and are supported by the Regional Trauma Plan.

6. Finalize contracts: Trauma Consultant Physician and Finance.

   Consultants to the regional staff are needed for special program activities. An experienced and nationally recognized Trauma Consultant Physician has been employed to assist in the development of the Regional Trauma Program. This will assure the Region access to national influence. An independent accounting organization will be employed to assist in the financial obligations of the region, i.e., receipt and disbursement of funds from the Trauma Care Trust Fund to physicians and hospitals as well as to the Region.

7. Prepare a regional trauma plan with all components as identified in the Mississippi Trauma Care System Regulations.

A regional trauma plan is required as part of program development. This plan will be produced, approved by the State, and amended as the region program develops.

8. Obtain approval of the required trauma plan by SETCR Board of Directors.

   A regional plan must be approved by the SETCR Board of Directors and submitted to the State for approval.

9. Hire part-time personnel: Regional Trauma Medical Director.

   See #5

10. Obtain approval of the regional trauma plan by the Mississippi State Department of Health, Bureau of EMS / Trauma.

    See #7

11. Coordinate regional performance improvement (PI) programs and report same annually to the state.

    The State intends to base all future regional designations of trauma center designations upon activities conducted by the Region and patient outcome data. Annual results must be reported to and accepted by the State on an annual basis.

12. Facilitate interfacility transfer of trauma patients with developed pre-arranged regional transfer agreements.

    Appropriate and timely transfer of trauma patients among trauma centers must be conducted. Pre-arranged regional transfer agreements will be developed with all regional facilities. An annual

evaluation of these agreements will be conducted and will serve as the basis for amendments if needed.

13. Coordinate the regional pre-hospital (EMS) system.

    The pre-hospital (EMS) system in Mississippi is currently being coordinated through the Mississippi State Department of Health, Bureau of EMS / Trauma. Regional staff will coordinate the existing pre-hospital providers through a subcommittee – SETCR Pre-hospital Subcommittee. This will include representatives of licensed ambulance companies and first responder/fire – rescue groups. Utilization of these groups for appropriate response to victims of trauma will be outlined in the Regional Trauma Plan.

14. Establish a regional trauma registry for SETCR for system evaluation.

    With the employment of a Regional Trauma Registrar and the purchase of the computer hardware necessary to house the State's Trauma Registry, a regional trauma registry has been established for system evaluation. Data from regional trauma centers will be forwarded to the regional registry on a quarterly basis. The Region will in turn share this information with the State and use it as a foundation for all program activities.

15. Approve certification to the Mississippi State Department of Health, Bureau of EMS / Trauma that the required plan is functioning as designed and approved.

On or before July 1 of each year, regional staff will formally notify the State that its regional plan is functioning and of any amendments developed during the past year. This certification is required in the Trauma Rules and Regulations.

16. Hire part-time personnel: Trauma Registrar.

    See #5

17. Develop, assess, and modify trauma system policy to accommodate trauma system activity.

    Trauma system policies are needed to guide regional system development and are required by the State. As the Region matures, policies will be developed in accordance with these rules.

18. Assess/research the medical needs for air transport services in Jasper, Jones, and Wayne Counties. If appropriate and medically justified, membership opportunities for these counties will be negotiated between SEMAAD and the political subdivisions of those counties.

    Ten of the thirteen counties which make up the SETCR are members of a public, non-profit licensed air ambulance program (Southeast Mississippi Air Ambulance District). This program offers rapid air transport form scene to hospital and for interfacility transfers. The three regional non-member counties will be afforded an opportunity to join this program.

19. Track patients from the scene of injury through the regional trauma system and rehabilitation.

Using the pre-hospital patient encounter form, the trauma registry and other related data, the Region tracks patients from the onset of injury through rehabilitation. The linkage of such data will serve as a basis for program adjustments.

20. Develop, implement, and begin the evaluation of regional pre-hospital trauma triage criteria.

    Criteria for pre-hospital triage of trauma patients has been developed and is being implemented throughout the Region. The effectiveness of the criteria will be adjusted as evaluation activities dictate.

21. Train regional pre-hospital personnel in adopted pre-hospital trauma triage criteria.

    Using the Pre-hospital Subcommittee, associated personnel will be trained in the Region's trauma triage criteria. Using the databases of the region, performance indicators and other compliance tools will be developed in order to effectively evaluate these criteria.

22. In coordination with the state's public information, education, and prevention plan, begin the development of a regional public information, education, and prevention plan.

    Prevention strategies to effect lifestyle changes are proven to be effective in reducing the incidence of traumatic injury. Using the State's public information, education, and prevention plan, the Region will develop local initiatives. These will keep the public abreast of the

system as it develops and will share local information related to injury prevention.

23. Develop and formalize mutual aid agreements with all regional EMS providers as well as with providers in contiguous trauma regions in and out of state.

    Mutual Aid Agreements with regional EMS providers and with providers in contiguous trauma regions will be developed. Once developed, these agreements assure the region access to additional resources when needed as a result of system overload. These will be reviewed and renewed annually.

24. Begin the development of a regional First Responder/Rural Rescue plan.

    See #13

25. Assess and monitor the resources of the SETCR.

    A resource inventory will be conducted. This inventory will document the availability of equipment, personnel, and facilities needed for the care of the trauma patient. Participant counties and providers within will be responsible for notifying the Region of the loss or the addition of resources annually.

26. Coordinate the SETCR plan for public information, education, and prevention with local chapters of support groups and organizations like AARP, MADD, SADD, Red Cross, etc.

    See #22

27. Share information regarding the SETCR with local political subdivisions and in region members of the Mississippi Legislature.

    Regional staff will prepare an annual report of all program activities. This report will be shared with the State and all regional trauma system report groups.

III. Implementation Schedule

The detailed objectives of the SETCR for FY 2005 are listed below:

- Finalize contract between SETCR and AAA
  - Completed

- Facilitate and direct the financial support of the SETCR from local, state and federal services, if any.
  - Target date: Ongoing

- Assist hospitals with the trauma center designation process.
  - Target date: Ongoing

- Facilitate all meetings of the SETCR Board of Directors and other committees established by the Board, i.e., regional advisory committees, clinical, administrative, and system committees
  - Target date: Ongoing

- Hire part-time personnel: Trauma Nurse and Regional Secretary
  - Completed

- Finalize contracts: Trauma Consultant Physician and Finance
  - Completed

- Prepare a regional trauma plan with all components as identified in the Mississippi Trauma Care System Regulations
  - Completed

- Obtain approval of the required trauma plan by SETCR Board of Directors
  - Completed

- Hire part-time personnel: Regional Trauma Medical Director
  - Completed

- Obtain approval of the regional trauma plan by the Mississippi State Department of Health, Division of EMS
  - Completed

- Coordinate regional performance improvement (PI) programs and report same annually to the state.
  - Target date: Ongoing

- Facilitate interfacility transfer of trauma patients with developed pre-arranged regional transfer agreements.
    - Target date: Ongoing

- Coordinate the regional pre-hospital (EMS) system.
    - Target date: Ongoing

- Establish a regional trauma registry for SETCR for system evaluation.
    - Completed

- Approve certification to the Mississippi State Department of Health, Division of EMS that the required plan is functioning as designed and approved.
    - Completed

- Hire part-time personnel: Trauma Registrar
    - Completed

- Develop, assess, and modify trauma system policy to accommodate trauma system activity
    - Target date: Ongoing

- Assess/research the medical needs for air transport services in Jasper, Jones, and Wayne Counties. If appropriate and medically justified, membership opportunities for these counties will be negotiated between SEMAAD and the political subdivisions of those counties.
    - Target date: Ongoing

- Begin tracking of patients from the scene of injury through the regional trauma system and rehabilitation.
    - Target date: Ongoing

- Develop, implement, and begin the evaluation of regional pre-hospital trauma triage criteria.
    - Target date: Ongoing

- Train regional pre-hospital personnel in adopted pre-hospital trauma triage criteria.
    - Target date: Ongoing

- In coordination with the state's public information, education, and prevention plan, begin the development of a regional public information, education, and prevention plan.
    - Target date: Ongoing

- Develop and formalize mutual aid agreements with all regional EMS providers as well as with providers in contiguous trauma regions in and out of state.
    - Target date: Ongoing

- Begin the development of a regional First Responder/Rural Rescue plan.
    - Target date: Ongoing

- Assess and monitor the resources of the SETCR
    - Target date: Ongoing

- Coordinate the SETCR plan for public information, education, and prevention with local chapters of support groups and organizations like AARP, MADD, SADD, Red Cross, etc.
    - Target date: Ongoing

- Share information regarding the SETCR with local political subdivisions and in region members of the Mississippi Legislature.
    - Target date: Ongoing

IV. Regional Administration

The SETCR is a 501-C3 not for profit public organization that is governed by a 10-member Board of Directors. The Board consists of representatives from the 10 participating hospitals within its 13-county area (appendix). Organized in 1999 as authorized by Mississippi law and related rules entitled “The Mississippi Trauma Care System Regulations,” the SETCR elected to contract for program administration as authorized in the referenced rules, Section V, paragraph 5.2, entitled “Operation of a Trauma Care Region.” That section states in part that

> “Such management may be carried out by an appointed executive manager, by contracting for management services, or by some other means to be approved by the Department.”

SETCR requested approval from the Mississippi State Department of Health, Division of Emergency Medical Services (Department), of a management services contract with AAA in Hattiesburg, Mississippi. Approval was granted by the state in December 2000 in a letter to the SETCR Board President (appendix).

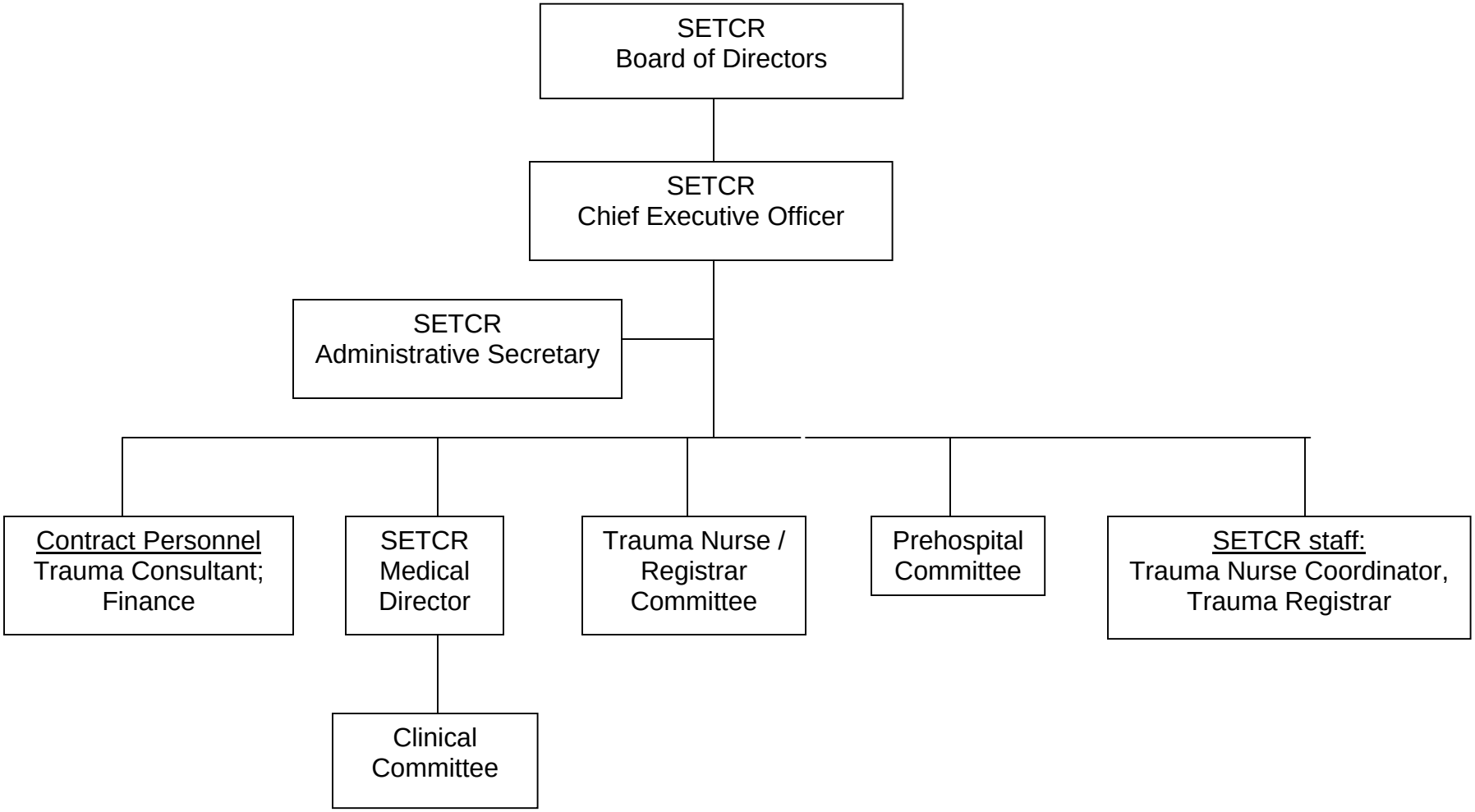
As a result of an annual contract negotiated between the SETCR and AAA, further development of an inclusive trauma care system is directed by the CEO of AAA.

Renewable annually on or before July 1st, this contract authorizes the AAA CEO to assume additional duties as CEO of SETCR.

Job tasks included in this management contract include the following:

- Prepare a regional trauma plan with all components as identified in the Mississippi Trauma Care System Regulations
- Obtain approval of the required trauma plan by SETCR Board of Directors
- Obtain approval of the regional trauma plan by the Mississippi State Department of Health, Bureau of EMS / Trauma
- Approve certification to the Mississippi State Department of Health, Bureau of EMS / Trauma that the required plan is functioning as designed and approved
- Facilitate all meetings of the SETCR Board of Directors and other committees as may be established by the Board, i.e., regional advisory committees, clinical, administrative, and system committees
- Facilitate and direct the financial support of the SETCR from local, state and federal sources, if any
- Establish and manage a regional trauma registry for SETCR for system evaluation.
- Coordinate regional performance improvement (PI) programs and report same annually to the state
- Facilitate interfacility transfer of trauma patients with developed pre-arranged regional transfer agreements
- Assist hospitals with the trauma center designation process
- Coordinate the regional pre-hospital (EMS) system

Southeast Trauma Care Region (SETCR) Organizational Chart



SETCR Personnel

The success of the developing trauma system among the member counties of the SETCR may eventually dictate the fulltime availability of a regular trauma system staff. This plan reflects a part-time staff, supported by contractual personnel, that is responsible for developing the regional program and enhancing the knowledge and cooperation of trauma support staff and facilities throughout the region.

Following the concepts outlined in the National Model Trauma Plan, the Mississippi Trauma Care Systems Regulations, and the experiences of other trauma systems throughout the country, the initial SETCR staff (all part-time/contractual) identified in this plan are as follows: CEO, Regional Medical Director, nationally recognized consultant trauma physician, regional trauma nurse coordinator, regional trauma registrar, contractual accounting firm, and a regional administrative secretary.

Chief Executive Officer: Is responsible, under direction of the SETCR Board of Directors, for the trauma system, to include planning, implementation, and management of the inclusive regional trauma system.

Regional Trauma Medical Director: Using the expertise of at least one consultant trauma system physician, the Regional Trauma Medical Director directs the development of the medically related system components. Working with a regional Clinical Committee of the SETCR, the Regional Trauma Medical Director leads the multidisciplinary activities of the regional trauma program; analyzes the impact and

results of the system and works with the CEO and SETCR Board of Directors to make appropriate modifications to assure the highest possible level of patient care.

Regional Trauma Nurse: The Regional Trauma Nurse Coordinator works closely with the Regional Trauma Medical Director as well as the CEO to assist in system design and evaluation as both relate to nursing and other ancillary staff. This nurse works with all regional facilities' trauma nurses regarding regional issues as well as specific facility issues.

Regional Trauma Registrar: The Regional Trauma Registrar manages the regional trauma registry and assists the CEO, the Regional Trauma Medical Director, and the Trauma Nurse in system evaluation.

Secretary: The Regional Secretary assists the CEO with telephone calls, messages, and general correspondence. Additionally, the secretary helps facilitate all related SETCR meetings.

Consultant Trauma Surgeon: A physician with nationally recognized trauma system expertise, assists the Regional Trauma Medical Director and medical subcommittee in the medical design and evaluation of the system. He also assists regional trauma facilities with internal trauma program issues and facility designation.

Contract Financial Services: All financial affairs of the SETCR are handled by contract with a CPA firm. Duties include collection of billings from all trauma centers and eligible physicians within the SETCR and payments as related to the approved SETCR annual budget.

Support Services

The SETCR needs a regional office facility to conduct all regional administrative tasks. The AAA Ambulance Service office facility serves as that facility and supplies related office needs (supplies, telephones, etc.) Additionally, adequate meeting space is available sufficient to host all SETCR Board meetings and other related subcommittee meetings.

Three committees assist the SETCR and its regional management structure – Clinical, Trauma Nurse / Registrar, and Prehospital committees. See the Performance Improvement section for a detailed discussion of each committee.

SETCR Financial Management

Currently, funding of all program activities is provided by the State through annual allocations to designated trauma regions with funds available in the Mississippi Trauma Care Trust Fund. The State provides funding for administrative management and hospital/physician reimbursement for indigent patients meeting the criteria for regional trauma registry. No other funding sources are currently available. The SETCR Board of Directors, however, has begun deliberations regarding the need for local funding to support regional activities as the system matures. One possibility, for example, is an assessment from hospital facilities according to level of trauma center designation.

The State Ethics Commission has ruled that State provided funding may not be manipulated by the Region. However, should funds be received from other sources (federal, local, etc.), these funds could be “managed by the region.”

V. Medical Organization

There are eleven hospitals within the geographic area of the SETCR. Currently, four hospitals (Forrest General Hospital – Level II, South Central Regional Medical Center – Level III, Crosby Memorial Hospital – Level IV, and Wayne General Hospital, Level IV) have been designated as trauma centers. However, each of the other participant hospitals has a physician representative serving on the Clinical Committee of the SETCR. This approach to regional organization assures medical system leadership of the regional trauma program on an equal basis. Additionally, a trauma physician has been designated by SETCR to serve as the Regional Medical Director for the trauma system. This physician, working through the regional Clinical Committee, leads the clinical activities of the regional trauma program.

Each participant hospital within the SETCR serves as a local medical control point (base station hospital) for the local pre-hospital provider. Each pre-hospital provider has a medical director and a medical control plan which is required by the State for licensure of the pre-hospital provider's service. During FY 2005, the SETCR will continue to review all of these services' medical control plans for consistency.

VI. Inclusive System Design

The inclusive design of the SETCR trauma system is founded upon the goal of providing optimal medical care to all injured persons within its boundaries. Additionally, the entire continuum of care -- prevention, pre-hospital, acute, and rehabilitative care -- has been considered in the system design of the SETCR.

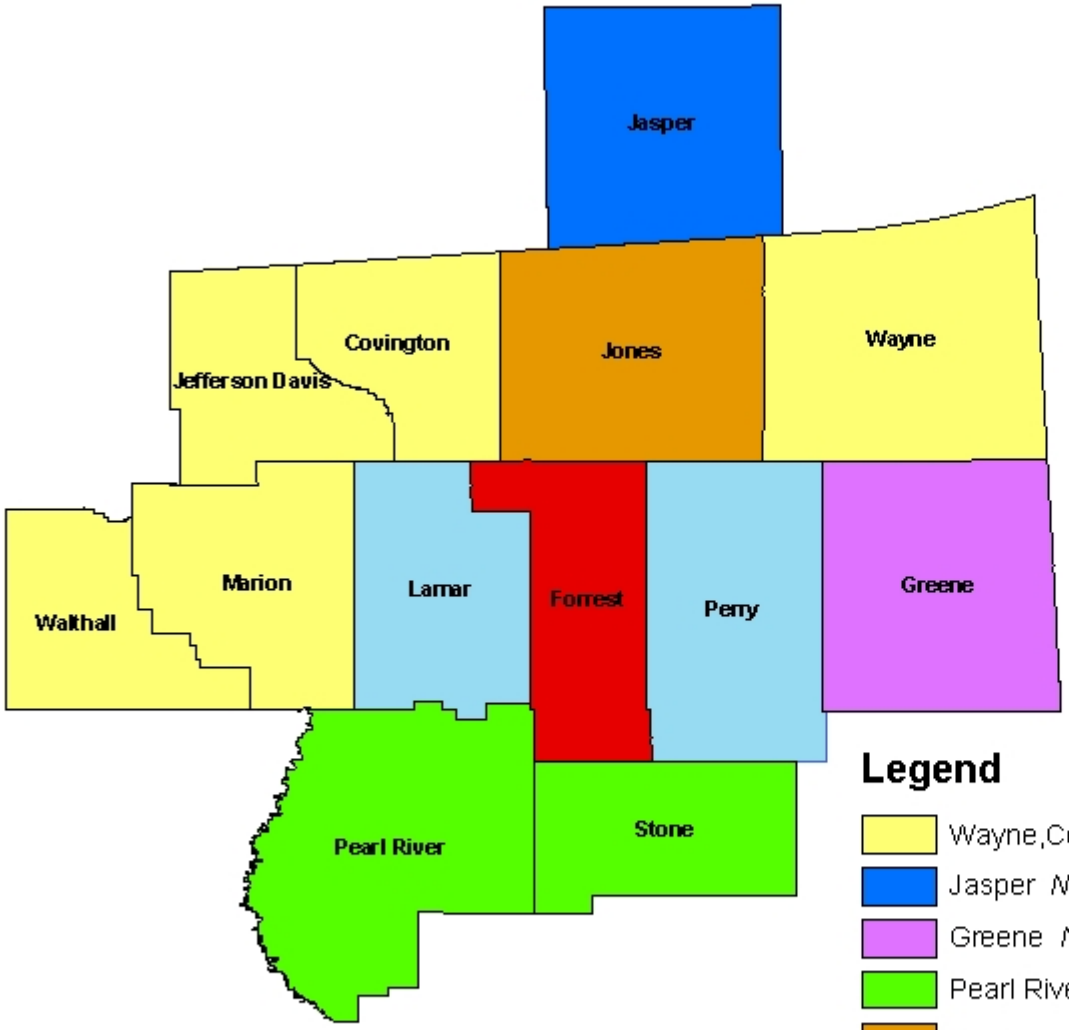
Facilities

The 13-county area of the SETCR has eleven hospitals with functioning emergency rooms.

Forrest County	Level II (Designated)
Jones County	Level III (Designated)
Pearl River County	Level IV (Designated)
Wayne County	Level IV (Designated)
Covington County	Level IV (Provisional)
Jefferson Davis County	Level IV (Provisional)
Walthall County	Level IV (Provisional)
Marion County	Level IV (Provisional)
Perry County	Level IV (Participant)
Stone County	Level IV (Participant)
Lamar County	Non-participating hospital
Greene County	No hospital facility
Jasper County	No ER in hospital

While the trauma centers are key components of the design of the SETCR trauma system, the non-designated hospitals and the needs of these counties without the availability of a hospital have been included in this plan.

Southeast Trauma Care Region



Legend

- Wayne,Covington,Jeff Davis,Walthall,Marion *Level IV (Provisional)*
- Jasper *No ER*
- Greene *No Hospital*
- Pearl River, Stone *Level IV (Participant)*
- Jones *Level III (Provisional)*
- Forrest *Level II (Designated)*
- Lamar, Perry *Non-participating*

VII. Interfacility Trauma Center Agreements

The SETCR reviewed transfer agreements from national trauma systems as well as within the State of Mississippi. A transfer agreement was developed and the Board of Directors, both Administrative and Medical representatives, reviewed, made recommendations, and mutually approved an SETCR Transfer Agreement. The final approval came from the Board of Directors during FY 2001. Each of the participating hospitals initiated Transfer Agreements during FY 2001 (Appendix).

Each transfer agreement remains valid, unless terminated by either participant. It is the responsibility of the attending physician at the transferring hospital to discuss the transfer with a member of the medical staff at the accepting hospital. The transferring hospital must provide medical treatment within its capacity that minimizes the risks to the patient's health. The transferring hospital must provide all medical records that are reasonably available at the time of transfer, along with any history, preliminary diagnosis, results of diagnostic studies, treatment provided, etc. The transferring hospital has the responsibility for arranging transportation and providing appropriate health care practitioner(s) to accompany the patient. The transferring hospital's responsibility for the patient's care must continue while the patient is being transported and does not end until the patient has been received by the receiving hospital.

These written agreements have established a system in which patients can be expeditiously moved to an institution which has been identified by prior agreement to be capable and willing to provide needed specialty services.

Additional tertiary care is available formally through agreements with the state's only Level I facility, University of Mississippi Medical Center in Jackson. In the unusual event that the Level I facility is not available for legitimate reasons beyond its control (trauma overload, equipment failure, mass casualty triage, etc.), out of state Level I facilities in New Orleans, Louisiana and Mobile, Alabama are available. Transfer agreements with these facilities are in place. Other special case needs of trauma patients are available by formal agreements with Delta Medical Center (burn center) in Greenville and Methodist Rehabilitation Center (rehabilitation) in Jackson. Additional burn care services are available in Mobile, Alabama at the University of South Alabama.

During FY 2005, all transfer agreements will be evaluated and may be revised should the evaluation dictate.

VIII. Regional Participation

Ten of the eleven hospital facilities and staff within the SETCR are committed to the development of a regional trauma program. The non-participating hospital, Wesley Medical Center, has chosen not to participate at this time.

IX. Operational System Design

Pre-hospital

The majority of the member counties of the SETCR have 20 plus years' experience in participation with a state recognized regional EMS system. The Southeast Mississippi Air Ambulance District (SEMAAD), a public non-profit organization, is the longest continuously operating helicopter program in the United States. Formed by special state legislation passed in the late 1960's, SEMAAD provides advanced life support pre-hospital response and inter-hospital transfer services for 10 of the 13 counties that form the SETCR. Only Jasper, Jones, and Wayne counties are not members of SEMAAD. Planning has begun regarding the air transport needs of region trauma patients within these three counties. Membership opportunities for these counties will be negotiated between the SEMAAD and appropriate political subdivisions this year.

The main components of the SETCR pre-hospital systems are advanced life support licensed ground ambulance systems and numerous first responder/fire rescue departments.

AAA Ambulance is a public non-profit ALS provider in Forrest, Jeff Davis, Marion, Perry, Stone, and Walthall Counties. AAA also services the Hattiesburg city limit area of Lamar County and the city of Poplarville and the northern half of Pearl River County. Emergystat, a private for-profit ALS provider, services Greene County, the city of Picayune, and the southern half of Pearl River County. ASAP Ambulance Service, a

private for-profit ALS provider, services Lamar and Jones Counties. Hospital based ALS providers provide services in Covington (Covington County Hospital), Jones (EMServ), and Wayne (Wayne County Hospital Ambulance Service) Counties. EMServ of Jones County also provides service to Jasper County.

Together these services have 51 emergency vehicles (ambulances) available for pre-hospital trauma response enhanced by the availability of the SEMAAD helicopter (Rescue 7). All vehicles conform to state requirements regarding design and equipment.

Ground Units

County	**Company**	**Number of Units**
Covington	Covington County Hospital	3
Forrest	AAA Ambulance	14
Greene	Emergystat, Inc.	1
Jeff Davis	AAA Ambulance Service	1
Jones	EmServ ASAP	10 3
Lamar	ASAP AAA Ambulance Service	2 1
Marion	AAA Ambulance Service	3
Pearl River	AAA Ambulance Service Emergystat, Inc.	1 4
Perry	AAA Ambulance Service	1
Stone	AAA Ambulance Service	1
Walthall	AAA Ambulance Service	1
Wayne	Wayne General Hospital	5
	Total Units: 51	

Mississippi has implemented a state of the art pre-hospital data collection system. All pre-hospital providers utilize this standardized data system. These services respond to over 40,000 calls for assistance annually. About 24% of those responses are related to injury (trauma). This system affords the SETCR the flexibility of integrating the pre-hospital data with the region's trauma registry data. During FY 2005, the SETCR will begin to track patients from the scene of injury through the regional system and rehabilitation. Pre-hospital providers are currently trained in trauma triage and principles of field resuscitation of trauma patients and meet all of the State requirements for education and certification.

During FY 2005, pre-hospital personnel in the SETCR will continue to receive additional training in the Trauma Triage Criteria adopted. Data collected will be used in evaluating compliance with these triage criteria and associated treatment protocols.

First Responders

Additional and valuable pre-hospital response comes through first responder programs within the public, law enforcement agencies and local rescue squads. These responders often significantly shorten initial treatment response times, which proves invaluable in rural states like Mississippi.

There are over 100 first responder organizations within the SETCR, not counting law enforcement agencies.

To date, meetings have been held with county fire coordinators and first responder organizations. These meetings assisted SETCR staff in determining the needs of these groups. With the First Responder Certification law implementation on July 1, 2004, the SETCR has devoted efforts toward the provision of training programs for these personnel. First Responder training programs will be offered during FY 2005.

County	# of First Responder Organizations
Covington	9
Forrest	10
Greene	8
Jeff Davis	7
Jones	20
Lamar	10
Marion	7
Pearl River	14
Perry	6
Stone	3
Walthall	6
Wayne	3

Some ambulance providers have coordinated networks with these groups as exemplified by the following example with Marion County and AAA Ambulance Service.

Marion County Firefighters' Association EMS First Responder Rules and Guidelines

The Marion County Firefighters' Association (MCFA) recognizes the need for prompt medical attention in cases of certain emergency situations. One means of reducing time from request for assistance to initiation of medical care is through the use of trained EMS First Responders. The First Responder provided basic emergency medical care until such time as more highly trained EMT's or Paramedics arrive on the scene. This early intervention by the First Responder may, in certain cases, make the difference between life and death. However, if such a system is to work efficiently, certain rules must be adhered to by the First Responder.

Each individual First Responder representing any fire department in Marion County may receive an EMS First Responder Identification Card through the Marion County Firefighters' Association if the fire chief signs this form and the First Responder pays the $5 yearly dues of the MCFA. You must be a paid member of MFCA and an active firefighter in Marion County to be eligible for the ID card.

I hereby agree to abide by all the following rules listed:

1. I agree to respond in a safe manner to the scene, abiding by the rules of the fire department or law enforcement agency on the use of red lights en-route. (First Responders are encouraged to have insurance on their personal vehicle.)
2. I agree to perform my duties to the best of my abilities and will not perform above my level of training.
3. On the scene, First Responders will work under the direction of the AAA Ambulance Crew. Until the ambulance crew arrives on the scene, the highest level First Responder is in charge of the scene. (The highest level First Responder may be an EMT-Basic, paramedic, or First Responder. Always follow the guidelines of who has been in the EMS field the longest; fire service time does not count toward EMS training and experience.)
4. I agree to re-certify every two years. I will keep a record of my continuing education units (CEU's), recording the number of hours training, explanation of the medical course topic, and will have the instructor sign the record.
5. I agree to keep all medical equipment and supplies in working order and sterile.
6. I must be an active member of a fire department in Marion County to be a First Responder.
7. I will maintain current CPR certification at all times.
8. I will provide the same standard of care as someone with the same training.
9. If the communications capabilities exist, only one First Responder should notify AAA when he or she is responding to a call and provide AAA with an on-scene report. All radio traffic will be kept to a minimum, and First Responders will use their fire department unit number as identification on the radio.
10. Only three first responders will be on the scene unless otherwise specified. On house calls, a maximum of three first responders will be in the house. This is to prevent upsetting the patient and to allow for room to work. Once AAA arrives on the scene, one or all First Responders may be asked to leave the house.
11. All First Responders are encouraged to take the Hazardous Materials Awareness Level class.
12. First Responders may be asked to handle scene control (bystanders), traffic control, setting up a landing zone (LZ) for Rescue 7, or retrieve supplies from the ambulance.
13. All First Responders are required to have their photo ID card clipped on upon arrival at the scene.

I have read the rules and guidelines and agree to abide by them as an EMS First Responder.

_____ _____
EMS First Responder Date

I support the MCFA EMS First Responder program and verify that the above named person is a firefighter with _____ Fire Department.

_____ _____
Fire Chief Date

The primary role of the EMS first responder is to reach the patient quickly and to provide stabilization until more highly trained personnel arrive on the scene.

First responders may be called out for the following emergencies:

Cardiac code or cardiac arrest	airway obstruction	respiratory distress
Unconsciousness patient	MVA's with injuries	significant overdose
Significant trauma	gunshot wounds	mass casualty incidents
Hazmat incidents	various house calls	patient lifting and loading

First Responders are usually paged out by Marion County Sheriff's Office, the department dispatcher or AAA Ambulance dispatch.

Upon arrival at the scene, the first responder should provide emergency medical care up to his/her level of training. Contact AAA and advise what the situation is, assist when AAA arrives on the scene, gather patient information for AAA personnel. In some cases, first responders may be asked to ride in the unit to the hospital to assist during transport.

First Responders MUST document any patient encounters and keep a record of each encounter.

- Name of patient
- Address of patient
- Address of patient if not at home
- Type of incident/problem
- Patient's condition
- Care provided to patient until ambulance arrives:
  - Vital signs, every 10-15 minutes and monitoring of patient until AAA arrives
- Condition of patient when patient care is transferred to ambulance crew

It is recommended that a small note pad be kept for this information to be written down. Record keeping is an important part of patient care. Maintain a log of all EMS calls that you make with the patient information on it.

Remember that patient identity, injuries, and care are confidential. Do not discuss the patients with others unless they are first responders also. Use caution then.

ID CARD INFO (Please print legibly.)

Name_____ Fire Department_____

Mailing Address_____

911 Address if different than above_____

Home phone #_____ Work # if you can leave for a call_____

Medical information: allergies, health conditions, drug allergies, etc. _____

_____

Date of birth_____ Height_____ Weight_____

Hair Color_____ Eye Color_____

Mutual Aid

While the SETCR boasts the availability of significant numbers of pre-hospital responders, mutual aid agreements with adjacent in-state and out-of-state EMS systems are needed. During FY 2005, the SETCR will coordinate/promote the expansion of these agreements among its EMS services and out-of-state providers if appropriate. (Appendix)

Injury Prevention

Mississippi has developed a state level strategy for injury prevention activities entitled "The Five-Phase Public Awareness and Prevention Campaign," the strategy (plan) defines and accepts the responsibility of the development of the injury prevention program and coordination of it through the regional trauma programs. However, to date, this plan has not been implemented by the State.

During FY 2005, the SETCR will continue the development of its plan for public information, education, and prevention. Additionally, it will seek involvement from local chapters of support groups like AARP, MADD, Red Cross, and others. When the State plan is scheduled for implementation, the SETCR will coordinate its activities accordingly.

Some prevention and outreach programs have been completed; others are still being planned.

The SETCR Board of Directors approved Project HomeSafe as a regional injury prevention project; it was completed during is FY 2002. The purpose of Project HomeSafe, a focused nationwide program, was to promote safe firearms handling and secure storage practices among all firearms owners.

During FY 2005, the group will continue to develop and review regional data and continue making recommendations as appropriate to SETCR committees. Additionally, this group will continue to work on education topics and injury prevention.

For the FY 2003 and FY 2004, one of the goals of the SETCR was to increase awareness of the use of seat belts and the effects that alcohol and drugs have on a person while driving throughout the communities in the Region. Each hospital has representatives who have been trained in the ENCARE program provided by the Emergency Nurses Association. This program involves all age groups and discusses the effects of drinking/drug use and driving. LEARN TO CARE is provided to elementary school children; DARE TO CARE is provided to those high school and college aged; and TAKE CARE is for older adults. Each facility representatives will provide presentations to the different age groups in their communities regarding drinking, drugs, and driving.

Education

The SETCR sponsored two TNCC courses during FY 2004. Thirty-two nurses were trained. All costs were paid by the SETCR. Two additional classes will be held in FY 2005.

During FY 2005, Trauma Nurse Coordinators and Registrars will be attending a state trauma workshop which will include the TOPIC course for performance improvement. SETCR will be paying for the registration fees for the coordinators and registrars.

During FY 2005, the SETCR will continue to sponsor scholarships for physician training in ATLS. Additionally, training for physicians in Rapid Sequence Induction (RSI) will be offered through the SETCR and Forrest General Hospital. Classes are currently scheduled with all clinical training scheduled on an individual physician basis.

Regional Outreach

Trauma Registry Workshops have been presented to all in-region Trauma Nurse Coordinators and Registrars. The Trauma Nurse Coordinators began to meet monthly in July 2000. The goal was to share information and prepare for inspections of Level IV facilities.

The Trauma Nurse Coordinators formalized and expanded its membership to include Trauma Registrars. The committee met quarterly. Goals of the committee were to

assist in developing the Regional Trauma Plan, to review issues and deficiencies, to plan education events for the SETCR, and to plan injury prevention projects.

During FY 2005 the group will continue to develop and review regional data and continue making recommendations as appropriate to SETCR committees. Additionally, this group will continue to work on education topics and injury prevention.

The Trauma Nurse Coordinators and Registrars meet on a quarterly basis. The goals of the Trauma Nurse Coordinators/Registrars committee are to assist in developing the Regional Trauma Plan, to review issues and deficiencies, to plan education events for the SETCR, to plan injury prevention projects and to collect data for performance improvement. Regional staff members assist different facilities with their trauma registry, data collection, and reporting.

X. Regional Critical Care

The critical care capabilities within the SETCR have not been formally assessed. During FY 2005, a critical care resource review will be conducted. The results of that detailed review will serve as the foundation for development of a critical care plan for the region.

As part of this initial regional trauma plan, four critical care areas are discussed: neurology coverage, burns, pediatrics, and rehabilitation.

Neurosurgery Coverage

The SETCR has one Level II (designated) trauma center, with four neurosurgeons actively participating.

Burn Coverage

Serious burn patients are transferred from the SETCR to burn centers in Greenville, Mississippi or Mobile, Alabama. Criteria for transfer are not formalized, but generally are as follows:

- Second and third degree burns over 10% or higher BSA in ages less than 10 and greater than 76 years
- Second and third degree burns over 20% or higher BSA in other age groups
- Second and third degree burns involving the face, eyes, ears, hands, feet, genitalia or perineum, or those that involve skin overlying major joints

- Significant electrical and chemical burns

All other burn patients are treated within the region, with most treated at the Level II trauma center.

Pediatric Coverage

Pediatric trauma patients are currently evaluated in the receiving emergency room; however, most are transferred, particularly neuro-pediatric patients, to the state's Level I trauma center. Formal transfer agreements will always be developed between the hospitals involved.

Rehabilitation

While limited rehabilitative services are available at the region's level II trauma center (orthopedic, spinal cord, and stroke), most patients are transferred to Mississippi Methodist Rehabilitation Center in Jackson, Mississippi or to HIS Rehabilitation Center and Life Care in Slidell, Louisiana. Formal agreements will be developed between the facilities involved.

XI. Performance Improvement

The purpose of the Performance Improvement Plan (PIP) is to establish a standardized method of trauma system evaluation for the Region. Using the results of these evaluations, changes appropriate for improved trauma care are factually justified for implementation.

Within the SETCR, the Regional Trauma Registry serves as the foundation of the PIP. Established at the Regional office facility at AAA Ambulance Service in Hattiesburg, Mississippi, the Regional Registry represents aggregate data from all participating hospitals (trauma centers) within the SETCR. Data is received quarterly by established Regional policy. The Regional Registry is managed by a Regional Registrar and one Regional Registry Assistant. In addition to the submission of trauma data to the State, reports are produced for the SETCR Board of Directors and three Regional Committees: Clinical, Trauma Nurse, and Pre-hospital. In addition to the Regional registry, nurses and physicians bring performance improvement issues to the table for evaluation and loop closure. These committees monitor trauma system development processes, outcomes, and all other related performance improvement processes.

The Clinical Committee (CC) is chaired by the Regional Trauma Medical Director. Members are appointed to the CC by each participating hospital. Member specialties are limited to surgery and emergency medicine. The CC meets quarterly and is charged with the development the physician components of trauma center/systems. Additionally, the CC is charged with monitoring the overall clinical performance of the

Regional Trauma Care System. To date, activities of the CC have focused on development of the trauma team, trauma team activation, criteria for trauma team activation, patient triage and destination protocols, interfacility transfer of trauma patients, trauma case review, professional training, and pre-hospital care.

The Trauma Nurse Committee (TNC) is chaired by the Regional Trauma Nurse Coordinator. Members are appointed to the TNC by each participating hospital. Membership is limited to the facility Trauma Nurse Coordinator and the facility Trauma Registrar. In some cases, one person may be performing the tasks of both. The TNC meets each month and is charged with the development of the participant hospital trauma program, as well as the out-of-hospital trauma program. To date, activities of the TNC have related to professional education, prevention, and performance improvement. Particular emphasis has been placed on the Mississippi Patient Encounter Form and its availability upon delivery of the trauma patient to the emergency room. This availability is monitored and reported monthly to the Trauma Region. Each pre-hospital provider receives a report which indicates its rate of form availability with regional trauma patients. With more than a year of data collected on this subject, the TNC can factually demonstrate improvement in this area.

The Pre-hospital Committee (PC) is chaired by a member elected from the membership of the committee. Membership consists of two representatives from each licensed ambulance service within the SETCR. The PC meets monthly and is charged with the development of all pre-hospital components of the SETCR. To date, activities of the PC

have related to EMS medical control, trauma patient treatment protocols, trauma triage and destination protocols, standardized response information including specific crash location data and the availability of the patient encounter form upon delivery of the trauma patient to the emergency room.

With recommendations from these three committees, the SETCR Board of Directors through its staff is positioned to direct policy development that affects regional trauma system improvements. Likewise, new trauma system issues can be assigned to a related committee for review. This assures the consensus process while guaranteeing appropriate expertise during the review. Because membership of these committees is representative of all participant hospitals, medical staff, support staff, and pre-hospital systems, “loop closure” for targeted system issues is greatly facilitated.

During FY 2003, the SETCR identified five trauma system issues for performance improvement. These are a) pediatric intubation attempts < 1, b) scene time < 20 minutes, c) hospital destination appropriate on all alpha patients, d) documentation of ambulance run record with patient brought to ED, and e) pre-arrival notification on all alpha patients of 6 - 10 minutes. These five indicators are related to pre-hospital response for patients considered to be alpha patients according to SETCR criteria. These issues were monitored monthly during FY 2004. Reports were turned in by pre-hospital agencies (ambulance services) at the PC meeting. Tabulation occurred by staff at the SETCR Regional Office. Reports were distributed to all appropriate committees for review. Recommendations from those committees flowed from the committee level

through the regional staff to the Board of Directors for review. In any case, the CC has final review prior to distribution to the Board of Directors. Recommendations for amendments to the SETCR Trauma Plan will be implemented upon adoption by the Board of Directors.

The following is a discussion of this performance improvement program. Evaluation tools are attached after the discussion. The following are audit indicators with thresholds:

a. Pediatric intubation attempts >1

   Pediatric is defined as age 14 or less.

   Threshold: 1 attempt should be made on pediatric intubation by an individual.

   This will be done by each EMS agency on all trauma registry patients.

b. Scene time >20 minutes

   Threshold: Scene time will be less than 20 minutes on all alpha patients.

   This will be done by each facility's coordinator/registrar. Data collected will be tabulated at each Registry Committee meeting.

c. Hospital destination appropriate on all alpha patients

   Threshold: Regional destination criteria followed on all alpha patients.

   This data will be obtained at each facility by the trauma coordinator/registrar. Data will be tabulated at each Registry Committee meeting.

d. Documentation of ambulance run record left when patient brought into the ED

   Threshold: 90% compliance

   This will be done by each facility's coordinator/registrar. Data collected will be tabulated at each Registry Committee meeting.

e. Pre-arrival notification on all alpha patients > 15 minutes

   Threshold: Notification to the ED is not less than 15 minutes on all alpha patients.

   This will be done by each facility's coordinator/registrar. Data collected will be tabulated at each Registry Committee meeting

In order to reduce variations of care, once an issue is identified, the pre-hospital agency will be asked to submit a plan to correct identified issue. The plan should include what the desired changes are, who is assigned to resolve the issue, and what action will be taken. Mississippi EMS statutes (ξ41-59-9, *Mississippi Code Annotated)* mandate pre-hospital provider's compliance with this Trauma Plan, including these Performance Improvement policies and procedures. Noncompliance with this policy will be considered a violation of the Mississippi law and EMS Rules and Regulations, and will be reported to the Division of EMS, MSDH for administrative enforcement.

Three months after the corrective action plan has been submitted, the issue identified will be re-evaluated. The pre-hospital agency will receive documentation of any findings, as well as any need for continued action.

The SETCR will abide by the laws of the State of Mississippi regarding confidentiality. Patient names or other identifying criteria will not be used in reports or audits that are distributed to the Board of Directors or to the State. Any records received by the Region will be stored under lock and key until destroyed.

XII. Regional Policies

The SETCR completed the process of state trauma center designation and finalized its administrative structure during the last quarter of FY 2001.

During FY 2002, the SETCR developed policies as required in Chapter IV, Section 4.6 of *The Mississippi Trauma Care System Regulations*.

Availability of Trauma Center Personnel and Equipment

PURPOSE: To ensure regulatory compliance with Mississippi Trauma Care System requirements regarding the availability of resources.

POLICY: All participating hospitals in the Southeast Trauma Care Region shall comply with Mississippi Trauma Care System requirements by maintaining a constant state of readiness consistent with their level of certification.

A. Surgeons, orthopedic surgeons, anesthesiologists, radiologists must be either present or on-call and promptly available. Emergency Department physicians must always be present in Level 2 & 3 hospitals and be available to Level 4 hospitals.

B. All hospitals shall have a designated trauma team consisting of physicians, specialists, nursing, and clinical ancillary personnel which should be either present or on-call and promptly available.

C. All facilities shall have a designated system for alerting and ensuring response times of appropriate staff. Methods of activation may include but are not limited to cell phones, pagers, two-way radios, or maintaining on-call staff on premises. Response times shall be documented and provided to the Region. (See Data Collection and Management.)

D. Surgeons, orthopedic surgeons, anesthesiologists, radiologists, neurosurgeons, and emergency medicine physicians must be appropriately boarded or fulfill alternate criteria per Mississippi guidelines and maintain adequate CEU's and general surgeons and emergency medicine physicians additionally be certified in

ATLS within three to five years. CRNA's must be licensed to practice in the state of Mississippi.

E. All equipment used in trauma care shall be in working order, adequate for need and level, and meet appropriate current FDA requirements for patient care.

F. Hospitals experiencing a temporary loss of equipment capability due to failure or repair shall arrange for replacement of equipment and/or proactively arrange for patient transfer or bypass as deemed necessary by that hospital's medical control.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Criteria for the Activation of the Trauma Team

PURPOSE: To provide hospitals in the Southeast trauma Care Region with guidelines for the activation of their respective trauma systems.

POLICY: All participating hospitals in the Southeast Trauma Care Region q shall establish criteria for the activation of their respective trauma systems. These criteria will be clearly noted in each institution's trauma policy. The following is intended to serve as a general guideline for the hospitals as each hospital within the Southeast Trauma Care Region is unique.

PROCEDURE

A. Immediate activation of the trauma system (Full Trauma Resuscitation)

1. Glasgow Coma Scale (OCS) <10
2. Systolic Blood Pressure <90 mm Hg
3. Respiratory Rate <10 or >29
4. Revised Trauma Score <11
5. Pediatric Trauma Score <9
6. Penetrating injury to the head, neck, torso, or extremities above the elbows or knees
7. Flail chest
8. Two or more proximal long bone fractures
9. Pelvic fracture
10. Limb paralysis
11. Amputation proximal to the wrist or ankle
12. Body surface burns >15% (second or third degree) or burns associated with other traumatic or inhalational injury
13. Trauma transfer that is intubated or receiving blood

14. Children under 12 with any of the historical flats outlined below

B. If none of the above apply, evaluate mechanism (Stable patient >12 years old)

1. Ejection from vehicle
2. Death in same passenger compartment
3. Extrication time > 20 minutes
4. Rollover MVC
5. High speed auto crash > 40 mph
6. Auto deformity >20 inches of external damage or intrusion into passenger compartment >12 inches
7. Auto vs. pedestrian or Auto vs. bicycle (>5mph)
8. Pedestrian thrown or over
9. Motorcycle crash >20 mph or separation of rider from the bike

If yes to any of above, the attending ER physician may, at his own discretion and medical judgment, activate a full trauma code or activate a modified trauma activation.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Coordination of Transportation

PURPOSE: The purpose of this is to provide guidance regarding the transportation of trauma patients.

POLICY: Trauma centers and EMS agencies shall cooperate to effectively transport a trauma patient to the appropriate trauma center.

A. The regional trauma system shall be activated through current methodology to include 911, *HP, or direct phone contact with a hospital.

B. Local ambulance provider(s) shall be dispatched to scene under authority of provider's medical control.

C. Local medical control shall direct ambulance provider to nearest appropriate trauma center and communicating necessary information to receiving trauma center if different facility.

D. Trauma center shall activate their response mechanism and facilitate transfer (if needed) to nearest appropriate higher-level facility. The method of transfer (air, ground) shall be determined by the provisions set forth in the transfer agreement and patient needs.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Data Collection and Management

PURPOSE: To provide a framework for collecting, recording, and utilizing data for purposes of trending, root cause analysis, and performance improvement

POLICY: The Southeast Trauma Care Region shall collect and report all necessary data as required by the Mississippi Department of Health. The Region shall also provide regular reports to the participating facilities.

A. All participating facilities shall report data and trending reports to the Southeast Trauma Care Region on a quarterly basis (calendar year).

B. The Southeast Trauma Care Region shall provide an annual report to the participating agencies and to the State Department of Health as necessary.

C. Data collected shall be used for performance improvement and system evaluation and shall include but is not limited to

1. Time flow data from reception of 911 to arrival at final destination
2. Mechanism of injury
3. Geographic location of injury and location of regional and final destination
4. Circumstances contributing to injury
5. Diagnosis Codes
6. Number of trauma deaths and transfers to include reason(s) for each

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Injury Prevention Programs

PURPOSE: To provide a format for the Southeast Trauma Care Region's participation in injury prevention activities.

POLICY: The Southeast Trauma Care Region shall participate in injury prevention activities.

A. The Southeast Trauma Care Region shall participate in injury prevention activities.

1. If desired, each facility may request assistance from the Region, in writing, at least one month before commencement of the class or event.
2. Assistance may consist of but not be limited to promotion, research, and acquisition of speakers.
3. Financial assistance from the Southeast Trauma Care Region may be provided by Board Resolution only. Individual facilities are other wise financially responsible for their activities.

B. The Southeast Trauma Care Region shall facilitate and encourage the coordination of injury prevention activities with other regions.

C. Each participating facility shall be encouraged to provide an injury prevention activity yearly.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Integration of Pediatric Hospitals

PURPOSE: To provide for pediatric trauma care

POLICY: The Southeast Trauma Care Region shall integrate pediatric hospitals into the regional system.

A. All designated trauma centers shall maintain a transfer agreement with a pediatric trauma center.

B. Each facility shall arrange for transfer according the agreement.

C. The Southeast Trauma Care Region shall facilitate and encourage the pediatric trauma center to provide educational and preventative informational resources into the Region's training, educational, and preventative services.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Trauma Care Coordination (Inter-region)

PURPOSE: To provide the mechanism for coordinating trauma care between the Southeast Trauma Care Region and other Regions located in Mississippi

POLICY: The Southeast Trauma Care Region will facilitate the establishment and maintenance of agreements between the participating hospitals and EMS agencies of the Southeast Trauma Care Region and those participating facilities and EMS agencies of neighboring and other applicable regions.

A. Trauma Centers shall establish and maintain transfer agreements approved by the Mississippi Department of Health.

B. Each EMS agency, to include hospital-based agencies, shall attempt in good faith to establish mutual aid agreements with all adjacent EMS agencies.

C. The Southeast Trauma Care Region shall maintain contact with neighboring Trauma Regions and the State Department of Health to monitor the status of and changes to the Mississippi Trauma Care System and its Regions. The Southeast Trauma Care Region shall incorporate any Mississippi Trauma Care System changes and consider changes in other region's plans into the Southeast Trauma Care Region's Performance Improvement Plan.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Intra-Regional Coordination

PURPOSE: To establish and maintain cooperation among the agencies participating in the regional trauma plan

POLICY: The Southeast Trauma Care Region shall develop and maintain a system designed to facilitate cooperation among the agencies participating in the regional plan.

A. The system shall provide for regional medical control to include criteria for activation of the trauma team. Regional medical control shall be in the form of cooperating individual participant hospitals. Regional medical control shall provide for

1. Criteria for bypass
2. Criteria determining a hospital's level of trauma team activation
3. Survey to determine capabilities of region's ability to provide trauma care

B. The system shall require the Southeast Trauma Care Region develop a transfer agreement for use among the participating hospitals located in the region.

C. Hospitals shall develop and provide to the Southeast Trauma Care Region their individual trauma plans and team activation procedures.

D. All agencies shall report to the Southeast Trauma Care Region their clinical and operational capabilities regarding trauma care. This is to include but is not limited to facilities, medical specialties and communication capabilities.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Professional and Staff Training

PURPOSE: To provide guidelines regarding the training of participants' healthcare providers in the care of trauma patients

POLICY: The Southeast Trauma Care Region shall facilitate and maintain the provision of training opportunities for participating facilities. Individual hospitals and physicians must maintain clinical qualifications as specified by the Mississippi Trauma Care System Regulations.

A. As specified by level designation, hospital staff is defined as nurses, allied health, and employed pre-hospital personnel.

B. The Southeast Trauma Care Region shall transfer any provided information regarding trauma triage guidelines and operational procedural changes associated with trauma care to all participating hospitals and EMS providers located in the region to maintain their current state of readiness. This may be through any means deemed appropriate by the Board.

C. Individual facilities are responsible for disseminating the information to their staff. The Southeast Trauma Care Region shall assist with the coordination and promotion of any multi facility educational sessions on trauma care.

D. The Southeast Trauma Care Region shall provide training to hospital staff on its trauma policies and procedures.

E. Trauma surgeons and emergency room physicians are required to maintain ATLS and a yearly average of 16 hours (48 over 3 years) of CME's as specified by hospital level and clinical specialty in the Mississippi Trauma Care System

Regulations. The Southeast Trauma Care Region shall relay any information regarding physicians' educational opportunities to the participating facilities.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Public Information and Education

PURPOSE: To provide a format for informing and education the general public residing in the Southeast Trauma Care Region and to provide regulatory oversight for the marketing and advertising by the agencies participating in the Trauma Plan.

POLICY: The Southeast Trauma Care Region shall develop and maintain a program of public information and education. Participating agencies shall cooperate with the Southeast Trauma Region regarding the promotion of their trauma programs.

A. The Southeast Trauma Care Region shall establish a network among its participating hospitals and other providers for the purpose of providing educational materials. The participating hospitals and other providers shall provide the informational and educational materials to the general public through any means deemed acceptable to the Regional Board.

B. The Southeast Trauma Care Region shall facilitate speakers, address public groups and serve as a resource for trauma education.

C. The Southeast Trauma Care Region shall assist its participating agencies in the development and provision of education to the public regarding the topics of injury prevention, safety education, and access to the system.

D. No participating agency shall use the terms “trauma center, trauma facility, trauma care provider” or similar terminology it its signs, printed material or public advertising unless the material meets the requirements of the Mississippi Trauma Care System Regulations as set forth in Miss Code Ann 41-59-1.

E. All marketing and promotional plans relating to the trauma program shall be submitted to the Southeast Trauma Care Region for review and approval, prior to implementation. Such plans shall be reviewed and approved based on the following guidelines:

1. The information is accurate
2. The information does not include false claims
3. The information is not critical of other system participants
4. The information shall not include any financial inducements to any providers or third parties.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

System Evaluation and Performance Improvement

PURPOSE: To improve performance of the system

POLICY: The Southeast Trauma Care Region shall review and evaluate the regional trauma care system to improve performance.

A. Each trauma center shall participate in the statewide trauma registry.

B. Each trauma center must develop an internal PI plan that minimally addresses the following key components:

1. A multidisciplinary trauma committee
2. Clearly defined authority and accountability for the program
3. Clearly stated goals and objectives, one of which should be the reduction of inappropriate variation in care
4. Development of expectations from evidenced based guidelines pathways and protocols
5. Explicit definitions of outcomes derived from institutional standards
6. Documentation system to monitor performance, corrective action, and the results of the actions taken
7. A process to delineate privileges credentialing all trauma service physicians
8. An informed peer review process utilizing a multidisciplinary method
9. A method for comparing patient outcomes with computed survival probability
10. Autopsy information on all deaths when available
11. Medical nursing audits
12. Reviews of pre-hospital care, and times and reasons for both trauma bypass and trauma transfers

C. The Southeast Trauma Care Region shall collect and report data to the State and to participating hospitals. (See Data Collection and Management.)

D. The Southeast Trauma Care Region shall evaluate and review the following for effectiveness:

1. The components of the regional system
2. Triage criteria and effectiveness
3. Activation of the trauma team
4. Notification of specialists and ancillary personnel
5. Trauma center diversions and transfers

E. The Southeast Trauma Care Region shall develop a performance improvement process that identifies root causes of problems and provides for continuous improvement of the system.

F. The performance improvement process shall provide for input and feedback from patients, guardians (pediatrics), and provider staff.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

System Organization and Management

PURPOSE: To provide organizational structure and administrative command and control for the Southeast Trauma Care Region

POLICY: The Southeast Trauma Care Region shall develop and maintain operations for the trauma program in the geographic region delegated by the State Department of Health.

A. The Region shall incorporate, develop and operate a Board of Directors and Regional Bylaws.

B. The Southeast Trauma Care Region voting membership shall consist of the geographically eligible hospitals participating in the Mississippi State Trauma Care System. Participating hospitals must be certified trauma centers.

C. Additional members may participate on a non-voting status after approval of the Regional Board.

D. The Regional Board shall develop and maintain a Trauma Plan in accordance with the requirements established by the Mississippi Department of Health.

E. The Regional Board shall appoint some person or entity that shall have administrative authority over the daily operations of the Southeast Trauma Care Region.

F. Voting and non-voting members shall participate in the Southeast Trauma Care Region as specified in the Board's Bylaws and other policies.

G. Each voting member shall develop and maintain a Mississippi Department of Health certified trauma program.

H. All information submitted from voting and non-voting members to Southeast Trauma Care Region shall be considered proprietary. Member organizations shall not use Region's proprietary information individual organization gain.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Data Collection and Reporting

PURPOSE: To provide a procedure for reporting data to the Southeast Trauma Care Region from participating designated trauma centers

POLICY: The regional trauma registry exists to identify and maintain information on all trauma patients within the region as required by the Mississippi State Department of Health criteria for trauma center designation. Data from in-region participating designated trauma centers must be submitted to the Southeast Trauma Care Region office no later than 45 days after the close of each fiscal year quarter.

A. All participating designated trauma centers shall forward all trauma data to the Southeast Trauma Care Region on a quarterly basis (no later than 45 days after the close of each quarter).

B. The Southeast Trauma Care Region shall collect all data submitted by the participating designated trauma centers and develop reports from the aggregate data for the Board of Directors, appropriate committees, and the State Department of Health as necessary.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

Trauma Triage and Destination Criteria

PURPOSE: To ensure the appropriate treatment and subsequent transport of individuals sustaining major traumatic injury within the Southeast Trauma Care Region.

POLICY: All ambulance services operating within the Southeast Trauma Care Region will utilize regionally approved policies, procedures, and protocols for the purpose of patient treatment and determining triage criteria and patient destination. All services must include, at a minimum, all regionally required policies, procedures and protocols, but may alter the format to meet the needs of each service and the approval of the local off-line medical director.

A. All trauma patients will receive initial evaluation for categorization as Alpha or Bravo using regionally approved criteria.

B. Patient interventions and treatment will be instituted following regionally approved treatment protocols, procedures, and/or onl8ine medical control.

C. Transport will be initiated as soon as possible from the scene. Scene time for traumatic injury should not exceed 10 minutes if possible. Patient destination will be in accordance with regionally approved destination criteria.

Date written:_____ Revisions:_____

Approval:_____ Revision approved by:_____

Wade N. Spruill, Jr.
Chief Executive Officer

XIII. Appendix

A. Management Approval Letter, MS State Department of Health

B. SETCR Board of Directors

C. Bylaws of the Southeast Trauma Care Region

D. Trauma Assessment Criteria – one example

E. EMS Mutual Aid Agreement – one example

F. Transfer Agreement – two examples

G. Performance Improvement Tracking Form

MISSISSIPPI
STATE DEPARTMENT OF HEALTH
Emergency Medical Services

570 East Woodrow Wilson
Post Office Box 1700
Jackson, Mississippi
39215-1700

F. E. Thompson, Jr., MD, MPH
State Health Officer

December 20, 2000

William C. Oliver, CPA, FHFMA
President Southeast Trauma Care Region, Inc.
c/o Forrest General Hospital
P. O. Box 16389
Hattiesburg, MS 39404

Dear Mr. Oliver.

I have received your request for an opinion regarding approval of a management contract for further development of your trauma region. Please be advised that such a contract between the Southeast Trauma Care Region and AAA Ambulance Service will be approved in accordance with the Mississippi Trauma Care Regulations, Chapter 5, paragraph 5.2. I would appreciate, however, that upon implementation of such a contract that up-to-date copies be forwarded to me for inclusion in the Southeast Trauma Care Region file in this office.

Please contact me if I can be of further assistance.

Sincerely,

Austin Banks, Acting Director
Emergency Medical Services

AB:WSjr:hdd
cc: File
Ingrid Dave Williams

601/576-7380
601/576-7373 FAX
www.msdh.state.ms.us

XIII - A

Southeast Trauma Region, Inc.

Member Hospitals and Board of Directors

County	Hospital	Administrator
Covington	Covington County Hospital	Mr. Clay Johnston PO Box 1149 Collins, MS 39428 601-765-6711 601-698-0180 fax
Forrest	Forrest General Hospital	Mr. Bill Oliver President PO Box 16389 Hattiesburg, MS 39404 601-288-4202 601-288-4441 fax
Greene	No Hospital	
Jasper	Ineligible Hospital	
Jefferson Davis	Prentiss Regional Hospital	Ms. Mary Curtis PO Box 1288 Prentiss, MS 39474 601-792-4276 601-792-2947 fax
Jones	South Central Regional Med Ctr	Mr. Doug Higginbotham Vice-President PO Box 607 Laurel, MS 39441 601-426-4000 601-426-4729 fax
Lamar	Non-participating Hospital	
Marion	Marion General Hospital	Mr. Jerry Howell Secretary PO Box 630 Columbia, MS 39429 601-740-2190 601-740-2244 fax

Pearl River	Crosby Memorial Hospital	Mr. Steve Grimm PO Box 909 Picayune, MS 39466 601-798-4711 601-798-3187 fax
Perry	Perry County Hospital	Mr. David Paris PO Box 1665 Richton, MS 39476 601-788-6316
Stone	Stone County Hospital	Mr. Wade Walters PO Box 97 Wiggins, MS 39577 601-928-6600 601-928-6475 fax
Walthall	Walthall General Hospital	Mr. Jimmy Graves 100 Hospital Drive Tylertown, MS 39667 601-876-2122 601-876-4190 fax
Wayne	Wayne General Hospital	Mr. Don Hemeter PO Box 1249 Waynesboro, MS 39367 601-735-7100 601-735-7181 fax

BYLAWS OF

SOUTHEAST TRAUMA REGION

A Mississippi Non-Profit Corporation

ARTICLE I

NAME AND OFFICES

Section 1. Name. The name of the corporation is Southeast Trauma Region, hereinafter referred to as the "corporation".

Section 2. Principal Office. The principal office of the corporation shall be located at 6051 U.S. Highway 49 South, Hattiesburg, MS, which shall also be the corporation's registered office in the State of Mississippi.

Section 3. Additional Offices. The corporation may also have offices at such other places, either within or without the State of Mississippi, as the board of directors may from time to time deem appropriate.

ARTICLE II

PURPOSES

The corporation is organized for the following purposes:

This corporation shall be a non-profit corporation.

A. The purpose of the corporation is to organize, implement, review and monitor the delivery of trauma care within the geographic trauma care region designated by the Mississippi State Department of Health, Division of Emergency Medical Services, and to disburse the funds for such purpose made available through the Mississippi Trauma Care

Systems Fund for the purposes set forth in Miss. Code Ann. § 41-59-75 (Supp. 1998) or from any other funding sources.

B. The purposes for which Southeast Trauma Region is organized are exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, or the corresponding provision of any future U.S. Internal Revenue law.

C. Notwithstanding any other provision of the Articles of Incorporation or these bylaws, this corporation shall not carry on any activities not permitted to be carried on by an organization exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986 or the corresponding provision of any future U.S. Internal Revenue law.

D. In the event of dissolution, the residual assets of the corporation will be turned over to one or more organizations described in Sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986 or the corresponding provision of any future U.S. Internal Revenue Code, of the federal, state or local government for exclusive public purpose.

ARTICLE III

MEMBERSHIP

Section 1. Eligibility. The membership of the corporation shall consist of hospitals that are providers of emergency medical services by way of medical treatment, medical transportation and medical treatment facilities within the Southeast Trauma Region as designated by the Mississippi State Department of Health, the Division of Emergency

Medical Services (the "EMS Region").

Section 2. Initial Members. The initial members of the corporation shall consist of the following hospitals:

1. Covington County Hospital
   P. O. Box 1149
   Collins, MS 39428-1149

2. Crosby Memorial Hospital
   P. O. Box 909
   Picayune, MS 39466-0909

3. Forrest County General Hospital
   P. O. Box 16389
   Hattiesburg, MS 39404-6389

4. Marion General Hospital
   P. O. Box 630
   Columbia, MS 39429-0630

5. Perry County General Hospital
   P. O. Drawer Y
   Richton, MS 39476

6. Prentiss Regional Hospital and Extended Care Facility, Inc.
   P. O. Drawer 1288
   Prentiss, MS 39474-1288

7. South Central Regional Medical Center
   P. O. Box 607
   Laurel, MS 39441-0607

8. Stone County Hospital
   P. O. Box 97
   Wiggins, MS 39577-0097

9. Walthall County General Hospital
   100 Hospital Drive
   Tylertown, MS 39667

10. Wayne General Hospital
P. O. Box 1249
Waynesboro, MS 39367-1249

11. Wesley Medical Center, Inc.
P. O. Box 16509
Hattiesburg, MS 39404-6509

Section 3. Voting Rights. In all meetings of members each member hospital shall be entitled to one (1) vote. Each member hospital may be represented by its director(s) serving on the board of directors (as hereinafter designated) or by any other individual designated by the member hospital.

Section 4. Resignation. Any member hospital may resign from any position with the corporation by submitting a written notice of resignation to the President through the Secretary.

ARTICLE IV

MEETINGS OF MEMBERSHIP

Section 1. Annual Meeting. There shall be an annual meeting of member hospitals during the month of November of each year in the principal office of the corporation on such date as is fixed by the board of directors or at such other time and place as shall be so designated. At such annual meeting the members shall elect a board of directors and transact such other business as may properly be brought before the meeting.

Section 2. Special Meetings. Special meetings of members may be called for any purpose by the chairman of the board, the president or the board of directors, either at their own request or upon written petition by at least five percent of the voting members. Any

such request shall state the purpose for which such meeting is called and designate the date, time and place for such special meeting.

Section 3. Notice of Meetings. Written notice of every meeting of the membership stating the place, date and hour of the meeting, shall be given either personally or mailed to each person not less than 10 days nor more than 60 days before the date of the meeting. Attendance at a membership meeting shall constitute a waiver of notice of such meeting and all objections to the place or time of meeting, or the manner in which it has been called or convened, unless a member states at the commencement of said meeting that the attendance of the member at such meeting is for the sole purpose of objecting to the holding of the meeting or the transaction of any business at the meeting.

Section 4. Quorum. Fifty-one percent of the membership present in person or by proxy shall constitute a quorum for the transaction of business, except as may otherwise be provided by law. If a quorum is not present or represented at any meeting of the membership, the presiding officer shall not attempt to conduct any business and those members present shall be dismissed.

Section 5. Voting. When a quorum is present at any meeting and unless otherwise provided by law, a majority of a member's voting, whether in person or represented by proxy, will be the act of the members.

Section 6. Presiding Officer. The chairman of the board shall preside at the meetings of members. If the chairman is not present then the president of the corporation shall preside; but if the president is not present then a person designated by the board of directors

shall preside. The secretary of the corporation shall act as secretary at meetings of members. If the secretary is not present then a person designated by the board of directors shall act as secretary.

Section 7. Representation at Membership Meetings. Each hospital member may be represented by any individual so authorized by the hospital member. Such authorization shall be filed in writing with the corporation. The corporation shall keep at its registered office or principal place of business a record of its members and its members' representatives, giving their names and addresses. The officer who has charge of the membership records of the corporation shall prepare and make, for every meeting of the membership or any adjournment thereof, a complete, alphabetically ordered list of the members entitled to vote at the meeting or any adjournment thereof.

Section 8. Action by Consent. Any action required or permitted to be taken at any meeting of the members may be taken without a meeting if a written consent to such action is signed by all members through their duly authorized representative and such written consent is filed with the minutes of its proceedings.

ARTICLE V

BOARD OF DIRECTORS

Section 1. General Powers. The board of directors shall be the governing body of the corporation and shall manage, direct and exercise all powers of the corporation and do all acts and things not prohibited by law, by the articles of incorporation or by these bylaws.

Section 2. Number, Selection and Term. The initial number of directors shall be

twenty-two, but the board of directors may increase or decrease the number of directors without amending the bylaws. The initial board of directors shall consist of one medical representative and one administration representative elected from each member hospital located within the EMS Region. Thereafter, each member hospital in the EMS Region shall be entitled to elect two members of the board of directors, one must be a medical representative and the other an administration representative. Membership on the board of directors shall be individual to the persons elected thereto and no director shall have any power of substitution, or of delegation of authority, with respect to membership on the board. In the event that a director elected by a member hospital is removed at the direction of said member hospital, the member shall be entitled to designate a replacement director. Each director shall serve until such time as a replacement director is designated in writing by the member hospital which the director represents.

Section 3. Removal or Resignation. Any director may be removed by the electing member hospital or by the affirmative vote of three-fourths of the directors in office. Any director may resign by giving written notice to the chairman of the board, the secretary and the electing member hospital. Unless otherwise specified in such notice, the resignation shall take effect upon delivery to the designated officers. A resignation need not be accepted in order to become effective.

Section 4. Vacancies. Any vacancy in the board of directors shall be filled by the hospital member whose director created the vacancy.

ARTICLE VI

MEETING OF DIRECTORS

Section 1. Annual Meeting. The annual meeting of the board of directors shall be held immediately following the annual meeting of the membership for the purpose of election of officers. Written notice of the time and place of the annual meeting shall be given to each director by personal delivery or by mail, phone or facsimile at least two (2) days before the meeting.

Section 2. Regular Meetings. Additional regular meetings of the board of directors may be held at such time and place as may be established by the board of directors. Written notice of the date, time and place of the meeting shall be given to each director by personal delivery or by mail, phone or facsimile at least two (2) days before the meeting.

Section 3. Special Meetings. Special meetings of the board of directors may be called by the chairman of the board or by the president. Special meetings shall be called by the president or by the secretary on written request of a majority of the board of directors. The secretary shall give written notice to each director of the date, time and place of the special meetings at least two days before the date of said meeting by personal delivery, mail, phone or facsimile.

Section 4. Quorum. At all meetings of the board of directors fifty-one percent of the directors shall constitute a quorum for the transaction of business. The act of a majority of the directors present at any meeting at which there is a quorum shall be the act of the board of directors, except as may be otherwise specifically provided by law or by these bylaws.

If a quorum shall not be present at the meeting of the board, the directors present shall not attempt to conduct any business and the presiding officer shall dismiss those directors present.

Section 5. Presiding Officer. The chairman of the board shall preside at all meetings of the board of directors. If the chairman of the board is not present the president shall preside; if the president is not present, then a person designated by the board of directors shall preside. The secretary of the corporation shall act as secretary of the meeting. If the secretary is not present a person chosen by the board of directors shall act as secretary.

Section 6. Action by Consent. Any action required or permitted to be taken at any meeting of the board of directors may be taken without a meeting if a written consent to such action is signed by all members of the board of directors and such written consent is filed with the minutes of its proceedings.

Section 7. Meetings by Telephone or Other Similar Communications Equipment. The board of directors may participate in a meeting by means of a conference telephone or similar communications equipment by means of which all directors participating in the meeting can hear each other, and participate in such a meeting shall constitute presence in person by such director at such meeting.

ARTICLE VII

OFFICERS

Section 1. Designation. The officers of the corporation shall be elected by the board of directors. The board of directors shall elect a chairman of the board, a president, a

secretary and a treasurer. The board of directors may elect a vice president or vice presidents, one or more assistant secretaries and/or assistant treasurers and other officers and agents as it shall deem necessary or appropriate. All officers of the corporation shall exercise the powers and perform the duties that shall from time to time be determined by the board of directors and the executive committee. Officers need not be members or directors of the corporation, except the chairman of the board and the president shall be directors. Any two or more offices may be held by the same person except the president and secretary.

Section 2. Term of, and Removal from, Office. Officers shall be elected initially at the first meeting of the board of directors and thereafter at the annual meeting of directors. Each officer of the corporation shall hold office until his successor is chosen and shall qualify. Any officer may be removed, with or without cause, at any time by the affirmative vote of a majority of the whole board. Any vacancy occurring in any office of the corporation may be filled for the unexpired term by the board of directors or the executive committee.

Section 3. Chairman of the Board. The chairman of the board shall be an officer of the corporation and, subject to the direction of the board of directors and the executive committee, shall perform such executive, supervisory, and management functions and duties as may be assigned to him from time to time by the board of directors. He shall, if present, preside at all meetings of members and of the board of directors.

Section 4. President. The president shall be the chief executive officer of the corporation and, subject to the direction of the board of directors and executive committee,

shall have general charge of the business, affairs and property of the corporation and general supervision over its other officers and agents. In general, he shall perform all duties incident to the office of president and shall see that all orders and resolutions of the board of directors or the executive committee are carried into effect.

Section 5. Vice President. The vice president, if any, or in the event there be more than one, the vice presidents as designated by the board of directors or executive committee, shall, in the absence of the president or in the event of his disability, perform the duties and exercise the powers of the president and shall generally assist the president and perform such other duties and have such other powers as may from time to time be prescribed by the president.

Section 6. Secretary. The secretary shall attend all meetings of the board of directors and the members and record all votes and the proceedings of the meetings in a minute book kept for that purpose. He shall perform like duties for the executive committee. He shall give, or cause to be given, notice of all meetings of members and meetings of the board of directors, and shall perform such other duties as may from time to time be prescribed by the board of directors or the executive committee, the chairman of the board, or the president.

Section 7. Treasurer. The treasurer shall have custody of the corporate funds and other valuable effects, and shall keep full and accurate accounts and financial records of the corporation and shall deposit all moneys and other valuable effects in the name and to the credit of the corporation in such depositories as may from time to time be designated by the board of directors or the executive committee. He shall disburse the funds of the corporation

shall have general charge of the business, affairs and property of the corporation and general supervision over its other officers and agents. In general, he shall perform all duties incident to the office of president and shall see that all orders and resolutions of the board of directors or the executive committee are carried into effect.

Section 5. Vice President. The vice president, if any, or in the event there be more than one, the vice presidents as designated by the board of directors or executive committee, shall, in the absence of the president or in the event of his disability, perform the duties and exercise the powers of the president and shall generally assist the president and perform such other duties and have such other powers as may from time to time be prescribed by the president.

Section 6. Secretary. The secretary shall attend all meetings of the board of directors and the members and record all votes and the proceedings of the meetings in a minute book kept for that purpose. He shall perform like duties for the executive committee. He shall give, or cause to be given, notice of all meetings of members and meetings of the board of directors, and shall perform such other duties as may from time to time be prescribed by the board of directors or the executive committee, the chairman of the board, or the president.

Section 7. Treasurer. The treasurer shall have custody of the corporate funds and other valuable effects, and shall keep full and accurate accounts and financial records of the corporation and shall deposit all moneys and other valuable effects in the name and to the credit of the corporation in such depositories as may from time to time be designated by the board of directors or the executive committee. He shall disburse the funds of the corporation

in accordance with the orders of the board of directors or the executive committee, taking proper vouchers for such disbursements, and shall render to the chairman of the board, the president, and the board of directors and the executive committee an account of all his transactions as treasurer and of the financial condition of the corporation.

ARTICLE VIII

COMMITTEES

Section 1. Executive Committee. The board of directors annually shall, by resolution adopted by a majority of the whole board, appoint from its membership an executive committee, composed of the chairman, the president and three (3) other directors. The secretary shall attend all meetings of the executive committee. The executive committee shall serve until the next annual meeting of the members.

(a) Powers of Executive Committee. During the intervals between the meetings of the board of directors, the executive committee shall have an may exercise all the powers and authority of the board of directors in the management of the business and affairs of the corporation to the extent permitted by law. The executive committee shall not (1) increase or decrease the number of directors, (2) dispose of the corporation's assets upon dissolution of the corporation, (3) amend the certificate of incorporation, (4) alter, amend or repeal the bylaws of the corporation, or (5) adopt an agreement of merger or consolidation of the corporation. All actions of the Executive Committee shall be reported to the Board of Directors at its next regular meeting.

(b) Presiding Officer. The chairman of the board shall be the chairman of and preside at

meetings of the executive committee. If the chairman is not present the president shall preside; if the president is not present then a member of the executive committee chosen by a majority of the members of the executive committee present shall preside. The secretary of the corporation shall act as secretary at meetings of the executive committee. If the secretary is not present then another member chosen by the executive committee shall act as secretary of the executive committee.

(c) Vacancies in Executive Committee. Vacancies in the executive committee shall be filled by the board of directors, but in the interim between meetings of the board of directors such vacancies may be filled by the executive committee.

Section 2. Other Committees. The board of directors, the executive committee, the chairman of the board and the president shall appoint other committees as may be appropriate from time to time.

ARTICLE IX

MEETINGS OF COMMITTEES

Section 1. Procedure and Meetings. Except as otherwise provided in these bylaws, each committee shall establish its own rules of procedure and shall meet at such time and place as shall be established by the committee. Each committee shall keep minutes of its meetings.

Section 2. Quorum. A majority of the members of any committee shall constitute a quorum. The affirmative vote of a majority of the members of the whole committee shall be necessary for the passage of any resolution, or the taking of any action.

Section 3. Action by Consent. Any action required or permitted to be taken at any meeting of any committee may be taken without a meeting if a written consent to such action is signed by all members of the committee and such written consent is filed with the minutes of its proceedings.

Section 4. Meetings by Telephone or Similar Communications Equipment. The members of any committee may participate in a meeting of such committee by means of conference telephone or similar communications equipment by means of which all persons participating in such meeting can hear each other, and participation in such a meeting shall constitute presence in person by any such committee member at such meeting.

ARTICLE X

NOTICES

Section 1. Form and Delivery. Whenever notice is required to be given to any director or member hospital it may be given in writing mailed to the director or member hospital at his/its address as it appears on the books of the corporation, unless otherwise specifically provided by law or these bylaws. Notices given by mail shall be deemed to be given when they are deposited in the United States mail, postage prepaid. Notice to a director may also be given by personally delivering written notice to the director or by telephoning notice to the director or by faxing such notice to the director at his address as it appears on the records of the corporation. Notices given by facsimile shall be deemed to be given when transmitted.

Section 2. Waiver. Whenever any notice is required to be given a written waiver

thereof signed by the person entitled to said notice, whether before or after the time stated therein, shall be deemed to be equivalent to such notice. Any member hospital who attends a meeting of members in person by its duly authorized representative or is represented in such meeting by proxy, without protesting at the commencement of the meeting the lack of notice thereof or any director who attends a meeting of the board of directors or any committee without protesting at the commencement of the meeting the lack of notice, shall be conclusively deemed to have waived notice of such meeting.

ARTICLE XI

DISSOLUTION

Section 1. Disposition of Assets. Upon the dissolution of the corporation, the board of directors shall, after paying or making provision for the payment of all of the liabilities of the corporation, dispose of all the assets of the corporation as provided in the Certificate of Incorporation and in Article II of these bylaws.

ARTICLE XII

FISCAL YEAR

The fiscal year of the corporation shall begin on the first day of October and end on the last day of September of the following year.

ARTICLE XIII

FINANCE

Section 1. Authorized Signatories. Except as the board of directors may generally or in particular cases authorize the execution thereof in some other matter, all checks, drafts,

and other instruments for the payment of money and all instruments of transfer of securities shall be co-signed in the name and on behalf of the corporation by the president and treasurer.

Section 2. Deposits. All funds of the corporation shall be deposited from time to time to the credit of the corporation in such banks, trust companies, or other depositories as the board of directors may select.

Section 3. Gifts. The board of directors may accept on behalf of the corporation any contributions, gifts, bequests, or devices for the general purposes or for any special purposes of the corporation.

Section 4. Annual Financial Statements. Not later than three months after the close of each fiscal year, the corporation shall cause to be prepared by a CPA, as follows:

a. A balance sheet showing in reasonable detail the financial condition of the corporation as of the close of the fiscal year.

b. A source and application of funds statement showing the results of its operation during its fiscal year.

c. An audit of financial records of the corporation using generally accepted auditing standards.

ARTICLE XIV

INDEMNIFICATION

The corporation shall indemnify and may obtain insurance with respect to, each person who is or shall be a director, officer, agent, or employee of the corporation from and against loss, damage, or expense on account of any action, suit, or proceeding brought or

threatened against such person by reason of his being or having been a director, officer, agent, or employee of the corporation, to the fullest extent permitted by law, including, but not limited to, the provisions of Miss. Code Ann. § 79-11-281 (1972).

ARTICLE XV

AMENDMENTS

The board of directors shall have authority to alter, amend or repeal these bylaws and to adopt new bylaws by an affirmative vote of a majority of the whole board; provided however, the board of directors cannot amend any provision in a manner which would adversely affect the corporation's exemption under Section 501(c)(3) of the Internal Revenue Code.

(End of Bylaws)

Southeast Trauma Care Region
ACTIVATION CRITERIA
REVISED January 2004 (effective 4/1/04)

ALPHA	BRAVO
Traumatic arrest	High speed MVC (> 40 mph)
Penetrating trauma to head, neck, chest, abdomen, pelvis	Rollover MVC
Burns covering > 20% BSA with suspicion of airway injury	Ejection from vehicle
Amputations (excluding digits)	Extrication time > 20 minutes
Traumatic injuries with neurological deficits	Other fatalities in the same vehicle
Flail chest	Auto vs. pedestrian
Extremity injury with vascular compromise	Auto vs. bicycle
Any history of hypotension at scene, but normal B/P now	MCC or ATV crash or with separation of rider from bike
1 long bone fracture with pelvic fracture	Falls ≥ 15 feet (pediatric-fall of ≥ 3 times their height)
≥ 2 long bone fractures (excluding tib/fib, radius/ulna)	≥ 4 patients from the same accident
Glasgow Coma Scale (GCS) < 10	

Vital signs with signs/symptoms of poor perfusion (altered mental status, delayed capillary refill)

	Adult	Pediatric (age 12 and under)	
Heart Rate	< 60 or > 120	1 year or younger	< 80 or > 180
		1-5 years	>160
		6-10 years	> 140
		> 10 years	> 120
Resp. Rate	< 10 or > 40	≤ 5 years	< 20 or > 60
		> 5 years	< 10 or > 40
Systolic B/P	< 90	≤ 5 years	< 70
		> 5 years	< 90

MUTUAL AID AGREEMENT

American Medical Response – South Mississippi
and
AAA Ambulance Service, Inc.

THIS AGREEMENT, entered into by and between American Medical Response (AMR) South Mississippi, and AAA Ambulance Service, Inc. (AAA Ambulance).

WHEREAS, pursuant to state laws and local ordinances and contracts, both AMR and AAA ambulance are licensed ambulance providers in Mississippi; and,

WHEREAS, some of the service areas of the two parties are adjacent to each other; and,

WHEREAS, each party provides ambulance vehicles and related equipment staffed with sufficient personnel to cover reasonably foreseeable demand for ambulance services throughout its respective designated service area; and,

WHEREAS, extraordinary situations may occur that will over-tax the ability of either service to provide prompt and efficient ambulance service to their respective service areas; and,

WHEREAS, each party acknowledges that it is authorized to enter into mutual aid agreements; and,

WHEREAS, AMR and AAA Ambulance desire to enter into this Mutual Aid Agreement pursuant to which either party may, at its option, request ambulance response by the other party into the requesting party's designated service area, subject to the conditions set forth herein,

NOW, THEREFORE, the parties agree to the following:

1. MUTUAL AID – In the event either party to this Agreement receives, through its dispatch facilities, a request for ambulance response to a location within that party's own service area, which in relation to the then-current availability of that party's ambulances is such that, in the opinion of that party, would likely place an extraordinary burden on the system and compromise the system standard of care, that party (i.e., the *requesting party*) may, at its option, request back-up ambulance and/or manpower support from the other party (i.e., the *requested party*).

2. USE OF BEST EFFORTS – In the event the requested party determines that the request for mutual aid can safely be accepted without unreasonably jeopardizing coverage of its own service area, the requested party shall notify the requesting party of the location from which its nearest unit would respond if the request for mutual aid is confirmed. The requesting party shall then decide whether to confirm or cancel the request for mutual aid. If the request is confirmed, the requested party shall use its best efforts to respond to the call in a timely manner. Provided, however, that any such request may be refused by the requested party when, in the opinion of the requested party, accepting the request would unreasonably

jeopardize coverage and response time reliability within the requested party's own service area.

3. FINANCIAL RESPONSIBILITY – In the event a party to this Agreement accepts responsibility for responding to a request for assistance pursuant to this Agreement, such party agrees to respond promptly. Once a mutual aid request has been accepted, the party accepting the request shall assume full responsibility for billing the patient and/or any appropriate third-party payor directly. The requesting party shall have no financial responsibility for payment or reimbursement unless agreed to by both parties. Any fees collected for such service shall belong only to the party actually providing the service and there shall be no referral fee or other fee due to payable to or by the requesting party. In cases where a mutual aid response may result in the assessment of financial penalties in the requesting party's service area, the requested party shall have no responsibility relative to payment of such penalties.

4. CONCURRENT RESPONSE – This agreement may result in situations where both ambulance services are present simultaneously at the scene of an ambulance call.

5. RESPONSE ON OR NEAR CONGRUENT BOUNDARY – In situations where both services may respond to ambulance calls on or near the service area boundary, the service to arrive first on the scene shall begin treatment and if both services arrive on the scene, the service that has jurisdiction for the specific locations shall determine who will take control and who will transport the patient. If a call occurs directly on the boundary, and both services respond and are comparably staffed and equipped to meet the patient's need, the first service to arrive will have jurisdiction. If both services are not comparably staffed and equipped, the service which is better equipped and staffed to manage the patient's immediate needs shall determine who will transport the patient.

6. AUTHORITY FOR CONTROL OF PATIENT MANAGEMENT – Authority for patient management during a joint response shall follow the guidelines established by the Mississippi State Department of Health, Division of EMS: Patient management shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing prehospital emergency stabilization and transport.

7. RESPONSE IN OTHER PARTY'S AREA – If either party receives a request for emergency ambulance response in the other agency's service area, the call will be promptly referred to the party that has jurisdiction.

   7.1. Neither party will make an ambulance call that originates and terminates in the other's service area without prior approval from the party that services the area. It is acceptable, however, for one party to enter another party's service area for non-emergency calls to either pick up or deliver patients as long as origin and destination are not both within the other's service area.

8. RETURN TRANSPORTS – Unless otherwise stipulated, if one party transports a patient from its service area and delivers said patient to the other party's service area and the patient

requires transport back to the original party's service area, the party that made the original transport will be expected to make both calls.

9. LIMITATION OF AUTHORIZATION – Only services rendered by one party to this Agreement at the specific request of the other party to this Agreement shall be considered services rendered pursuant to this Mutual Aid Agreement. Such requests shall be considered official only when made by the requesting party. In the event an ambulance operated by either party spontaneously discovers an emergency incident in progress while passing through the other party's service area, the parties agree that the local provider's dispatch center shall be immediately notified of the nature and location of the incident, and the ambulance crew at the scene shall then render assistance. The crew at the scene may operate under their own standing orders to address life-threatening conditions in accordance with their level of training. Local protocols and medical direction should guide all other treatment and transportation decisions. Depending upon the nature of the incident and the estimated time of arrival of the nearest ambulance in the service area, the service area dispatch center may request and authorize transport by the unit on the scene (i.e., a "mutual aid request"), or may direct that the transport shall be made by an incoming unit. In the later case, the first unit on the scene shall not depart the scene until the second unit arrives, and shall assist in preparing and loading the patient for transport.

10. CLINICALLY QUALITY ASSURANCE – Both parties agree that the level of services provided pursuant to this Agreement shall be substantially clinically equivalent or appropriate for the situation at hand and in compliance with applicable local ordinances. "Substantial clinically equivalent" shall not necessarily require identical on-board equipment, training requirements, or medical protocols. Medical control authorities for each party authorize personnel from the adjacent service to function at their level in these mutual aid situations. Notwithstanding any other provisions regarding termination of this Agreement, either party's Medical Director may, at any time and in his sole discretion, revoke this medical control.

    10.1. Each party agrees when functioning as the requested party to cooperate fully and participate in any medical audit requested or conducted by the requesting party, involving mutual aid runs accepted by the requested party.

11. DISPATCH DOCUMENTATION - If resources exist, the parties hereto agree that the dispatch center for the requested party shall accurately document the response times for any mutual aid request accepted.

12. SPECIALIZED SERVICES – Unless otherwise restricted or regulated by local ordinance, specialized services, i.e., Mobile Intensive Care Transport, governmental contracts, air ambulance with accompanying ground transport, etc., shall be excluded from the provisions of this Agreement.

13. INDEMNIFICATION – Each party agrees to indemnify and hold harmless the other party and the political subdivisions within the designated service areas, including officers, agents and employees from and against any and all claims or suits for property damage or loss

and/or personal injuries, including death, for errors or omissions on the part of either party in any manner arising out of the services rendered pursuant to this Agreement. Such indemnifications for acts occurring or alleged to have occurred during the effective dates of the Agreement shall survive the terminations of this Agreement for any reason.

14. LIABILITY – Each service agrees to provide for itself, appropriate liability, auto, and Workers' Compensation insurance, in amounts as may be required by law.

15. TERM AND EFFECTIVE DATE – This agreement is non-assignable. The effective date of this agreement shall be February 1, 2001, and shall remain in effect until (i) the loss of either party's jurisdiction or license, or (ii) failure of any party to fulfill the terms of the Agreement. Either party may terminate this Agreement at any time by giving written notice delivered to the other party. The Agreement shall also be considered valid by successors to any of the parties signing hereto unless otherwise stipulated by the successor.

for AMERICAN MEDICAL RESPONSE – SOUTH MISSISSIPPI

Steven J. Delahousey — Title: Director of Operations

Steven J. Delahousey

Date: 2/9/01

for AAA Ambulance Service, Inc.

Wade N. Spruill, Jr. — Title: Chief Executive Officer

Wade N. Spruill, Jr.

Date: 2/12/01

P:\Mutual Aid\AAA Feb. 2001.doc

TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT ("Agreement"), made and entered into this 30 day of January, 200 1 by and between Forrest County General Hospital (hereinafter "Forrest General"), a Mississippi community hospital, and The University of South Alabama Burn Center (hereinafter "USA").

WITNESSETH:

WHEREAS, both Forrest General and USA, the "parties," are health care facilities providing services and access to patient care for the ~~residence~~ residents of their service areas, and

WB 1/23 WCO

WHEREAS, the parties have determined that it would be in the best interest of patient care and it would promote the optimum use of their facilities to enter into this Agreement for the transfer of patients from Forrest General to USA, and

WHEREAS, the parties desire to assure the appropriate and orderly transfer of patients from Forrest General to USA and, as well as, to maintain the desired level and continuity of care of patients so affected, the parties wish to coordinate their efforts to achieve the objectives and to cooperate in securing optimum use of their facilities and services during routine and emergency conditions.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, and for other valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

1. **TERM.** This Agreement shall commence on the date set forth above and shall continue for a period of one (1) year and shall be renewed automatically for successive periods of one (1) year, unless sooner terminated as hereinafter set forth.

2. **PATIENT TRANSFER.** Patient transfer to USA will be requested and accomplished for the purpose of securing a level of care or service that cannot otherwise be provided at Forrest General.

A. Transfer, when justified, must be accomplished by request from the patient's attending physician at Forrest General to an appropriate member of the medical staff of USA. It will be the duty of the attending physician and/or Forrest General to obtain the requisite certification that the benefits of transfer outweigh the risks involved (if required) and obtain from the patient, or a legally responsible person acting on the patient's behalf, whatever written request or consent for the transfer as may be required by federal and/or state law and regulation, including, but not limited to, 42 C.F.R. § 489.24 and Miss. Code Ann. § 41-41-3 (1972), as amended.

B. Prior to transfer, Forrest General shall provide medical treatment within its capacity that minimizes the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child.

C. If USA has available space and qualified personnel necessary for the treatment of the patient, it will inform Forrest General that it has agreed to accept transfer of the patient and agreed to provide appropriate medical treatment. Transfer may not be initiated until final approval has been given by USA. Patient transfer is subject to availability of services, beds and other resources that might be needed to care for the patient. USA agrees to provide necessary services when suitable accommodations are available, consistent with its mission and objectives.

D. In the event of a question as to the ability of USA to accept the patient, the administrator on call will render a final decision.

E. At the time of transfer, Forrest General will provide to USA all medical records (or copies thereof) that are reasonably available at the time of the transfer, including any records related to any emergency condition which the individual has presented, and including available history, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests, and the informed written consent or certification (or copy thereof) required for the transfer. Other records

(e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer.

F. Responsibility for the transfer of the patient to USA will rest with Forrest General. Forrest General shall have responsibility for arranging transportation for the patient, including selection of the mode of transportation and providing appropriate health care practitioner(s) to accompany the patient. The transfer should be effected through qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer (if necessary). Forrest General's responsibility for the patient's care shall continue while the patient is being transported and will not end until the patient has been received by the receiving hospital.

3. **PAYMENT FOR SERVICES.** Neither institution shall assume any responsibility for the collection of any accounts receivable other than those incurred as a result of rendering direct services to patients.

4. **ADVERTISING AND PUBLIC RELATIONS.** Neither party shall use the name of the other party in any promotional or advertising material without the express written consent of the other.

5. AUTONOMY. Both parties are independent contractors. Nothing herein shall be construed as to create a joint venture, partnership, or agency or employment relationship between the parties. The governing body of each institution shall have exclusive control of its policies, management, assets and affairs, and neither shall incur any responsibility by virtue of this Agreement for any debts or other financial obligations incurred by the other. Further, nothing in this Agreement shall be construed as limiting the rights of either institution to contract with any other facility on a limited or general basis, and nothing in this agreement shall alter the freedom enjoyed by either institution, nor shall it affect the independent operation of either hospital.

6. **LIABILITY.** Each party shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other party.

7. TERMINATION. This Agreement may be terminated by either party, with or without cause, by giving sixty (60) days written notice of its intention to withdraw from and terminate this Agreement. Additionally, the agreement shall automatically terminate in the event that either party fails to maintain its licensure or certification as issued by appropriate authorities, or if the ownership of either party is transferred or otherwise altered.

8. **NONWAIVER.** No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any term or condition of this Agreement.

9. **GOVERNING LAW.** This Agreement is made and entered into the State of ~~Mississippi~~ Alabama, and ~~Mississippi~~ Alabama law shall govern.

10. **ASSIGNMENT.** This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party.

11. **INVALID PROVISION.** In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

12. **AMENDMENT.** This Agreement may be amended at any time by a written agreement signed by the parties.

13. **NOTICE.** Any notice required or allowed to be given hereunder shall be deemed to have been given upon deposit in the United States mail, registered or certified, with return receipt requested and addressed as follows:

Bill Bush, Assist. Admin. of Finance, and
Arnold Luterman, M.D., Chairman of Surgery
USA Burn Center
2451 Fillingame Street
Mobile, AL 36617

William C. Oliver. President and
William H. Peters, M.D., VP of Medical Affairs
Forrest County General Hospital
P.O. Box 16389
Hattiesburg. MS 39404-6389

14. **BINDING AGREEMENT.** This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to this subject matter and supersedes any and all other agreements, either oral or in writing, between the parties with respect to this subject matter.

15. **HEADINGS.** The headings to the various section of this Agreement are for convenience only and shall not modify, define or limit the express provisions of this Agreement.

16. **COMPLIANCE WITH LAWS.** This Agreement is entered into and shall be performed by other parties in compliance with local, state, and federal laws, rules, regulations, and guidelines.

University of South Alabama Medical Center and Forrest General will obtain and maintain throughout the term of this agreement or any renewal thereof, professional liability coverage insuring, its employees, agents, and servants with limits of liability coverage of not less than $1,000,000.00 per occurrence and $3,000,000.00 annual aggregate. As evidence of such coverage, each will furnish to the other a certificate of insurance prior to commencement of this agreement and annually thereafter. Such certificate shall provide that the aforementioned overage cannot be materially altered or canceled without at least thirty (30) days written notice received by the other party. Failure of either party to obtain and maintain such coverage shall be grounds for immediate termination of this agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on the day and year first above written.

FORREST COUNTY GENERAL HOSPITAL

William C. Oliver, President

William H. Peters, M.D.
Vice President of Medical Affairs

UNIVERSITY OF SOUTH ALABAMA MEDICAL CENTER

1/23

Stephen H. Simmons
Assoc. V.P. Medical Financial Affairs

10/97

HOSPITAL TRANSFER AGREEMENT

This Transfer Agreement ("Agreement") is made as of January 8, 2001, by and between WESLEY HEALTH SYSTEM d/b/a WESLEY MEDICAL CENTER ("Hospital A") and FORREST GENERAL HOSPITAL ("Hospital B") and are sometimes individually referred to as "facility" and collectively as "facilities."

RECITALS

A. The parties desire to enter into this Agreement governing the transfer of patients between the two facilities located in Mississippi ("State").

B. The parties desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

Now, Therefore, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. **Transfer of Patients.** In the event any patient of either facility is deemed by that facility ("Transferring Facility") as requiring the services of the other facility ("Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein.

All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO"), any other applicable accrediting bodies, and reasonable policies and procedures of the facilities, and Emergency Medical Treatment Act [42 USC Sec. 1395dd].

Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **Responsibilities of the Transferring Facility.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer.

b. Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations.

c. Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility.

d. Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient.

e. Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care.

f. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient.

g. Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician.

h. Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including (i) records related to the patient's condition, observations of signs or symptoms, (ii) preliminary diagnosis, (iii) treatment provided, (iv) results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized. (v) a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible.

i. Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items.

j. Provide the Receiving Facility any information that is available concerning the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a health care assistance program established by a county, public hospital, or hospital district.

k. Notify the Receiving Facility of the estimated time of arrival of the patient.

l. Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician

or other qualified personnel if the physician is not physically present at the facility at the time of transfer.

m. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider.

n. Recognize the right of a patient to request to transfer into the care of a physician and hospital of the patient's choosing.

o. Recognize the right of a patient to refuse consent to treatment or transfer.

p. Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred.

q. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility.

3. **Responsibilities of the Receiving Facility.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

a. Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within 30 minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor.

b. Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility.

c. Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency.

d. Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility.

e. When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician.

f. Provide the Transferring Facility with a copy of the medical records of the patient that were generated at the Receiving Facility, if the patient is returned to the Transferring Facility by the Receiving Facility.

g. Maintain the confidentiality of the patient's medical records in accordance with applicable state and federal law.

h. Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient.

i. Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to the Transferring Facility, provide the items and services specified in Section 2 of this Agreement.

j. Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient.

k. Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provided.

l. Complete, execute, and return the memorandum of transfer form to the Transferring Facility.

4. **Billing.** All charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party coverage, Medicare or Medicaid, or other sources normally billed by that facility. In addition, it is understood that professional fees will be billed by the physicians or other professional providers that may participate in the care and treatment of the patient at usual and customary charges. Each facility agrees to provide information in its possession to the other facility and such physicians/providers sufficient to enable them to bill the patient, responsible party, or appropriate third partypayor.

5. **Re-transfer; Discharge.** At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be

transferred to the agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility.

6. **Compliance with Law.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. **Responsibility; Insurance.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **Term; Termination.**

a. The initial term of this Agreement ("Initial Term") shall be for a period of one (1) year(s), commencing January 8, 2001, unless sooner terminated as provided herein. At the end of the Initial Term and each Renewal Term (as hereafter defined), if any, this Agreement may be renewed for an additional term of one (1) year ("Renewal Term"), but only upon mutual written agreement of the parties.

b. In the event the parties continue to abide by the terms of this Agreement after the expiration of the Initial Term or any Renewal Term, this Agreement shall continue on a month-to-month basis.

c. Either party may terminate this Agreement without cause upon thirty (30) days' written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. This Agreement may be terminated immediately upon the occurrence of any of the following events:

(1) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately.

(2) Either facility loses its license, is convicted of a criminal offense related to health care, or is listed by a federal agency as being debarred, excluded or otherwise ineligible for federal program participation.

This Agreement may be renewed for subsequent one (1) year terms upon the mutual written consent of the parties.

9. **Mediation.** In the event of a dispute between [or among] any of the parties to this Agreement, the parties agree that the following procedure will be used in an

attempt to resolve the dispute prior to the pursuit by any party of other available remedies.

(a) A meeting (the "initial meeting") shall promptly be held at which all parties are present or represented by individuals with full decision-making authority regarding the matters in dispute.

(b) If within thirty (30) days following the Initial Meeting the parties have not succeeded in negotiating a resolution of the dispute, the dispute shall be submitted to mediation facilitated by a mediator ("Mediator"). The Mediator shall be a retired judge or mature practicing attorney. Each party shall bear its proportionate share of the costs of the mediation, including the Mediator's fee.

(c) The parties agrees to participate in good faith in the mediation and negotiations related t in the Initial Meeting and in all mediation conferences.

(d) If after a period of sixty (60) days following the mediation conference or any adjournment thereof, the parties are unable to resolve the dispute, either party may, if it so chooses, initiate litigation upon ten (10) days' written notice to the other party [ies].

10. **Miscellaneous**

(a) **Entire Agreement; Modification.** This Agreement contains the entire understanding of the parties with respect to this subject matter and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

(b) **Partial Invalidity and Governing Law.** If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement. This Agreement shall be construed in accordance with the laws of the State.

(c) **Notices**. All notices by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to Hospital A: Wesley Medical Center
5001 Hardy Street
Hattiesburg, MS 39402

If to Hospital B: FORREST GENERAL HOSPITAL
PO Box 16389
Hattiesburg, MS 39401
Attn: Sheila Shappley

or to such other persons or places as either party may from time to time designate by written notice to the other.

(d) **Waiver.** A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

(e) **Assignment; Binding Effect**. Facilities shall not assign or transfer, in whole or in part, this Agreement or any of Facilities' rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties and their respective heirs, representatives, successors and permitted assigns.

The Parties have executed this Agreement as of the day and year first above written.

WESLEY HEALTH SYSTEM, LLC d/b/a
WESLEY MEDICAL CENTER

By: Diane Reidy
Diane Reidy, Chief Executive Officer

FORREST GENERAL HOSPITAL

By: [illegible] VP MA

U:\WPDATA\TRANSFER.WPD

7 XIII - F

Performance Improvement Tracking Form

Date of report_____

Trauma registry #_____

Hospital_____

Location of issue:

_____ Prehospital
_____ Resuscitation
_____ Imaging
_____ Lab
_____ OR
_____ PACU
_____ ICU
_____ Floor
_____ Rehab
_____ Other _____

Complication, occurance, problem, or complaint:

Reported to_____ Reviewed by_____

Determination:

_____System related
_____disease-related
_____provider-related
_____cannot be determined

Preventability:

_____nonpreventable
_____potentially prevented
_____preventable
_____cannot be determined

Corrective Action(s):

_____Unnecessary
_____trend
_____education
_____guideline/protocol
_____Counseling

Comments:

Signature_____ Date_____

XIII - G